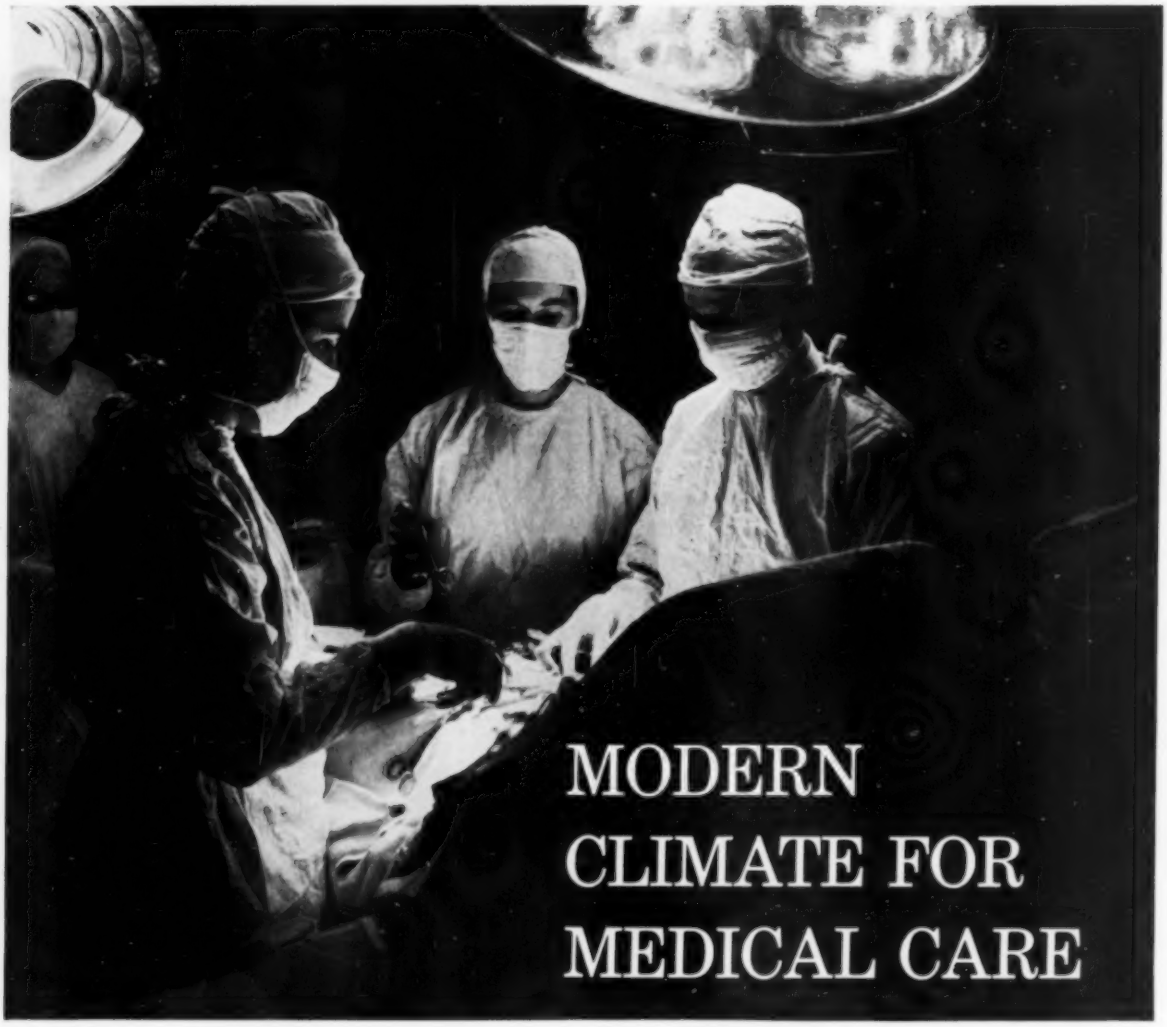
The Modern Hospital

FEBRUARY 1961

Patient's-eye view of Scott boom in special surgery at St. Barnabas Hospital, New York (page 88)



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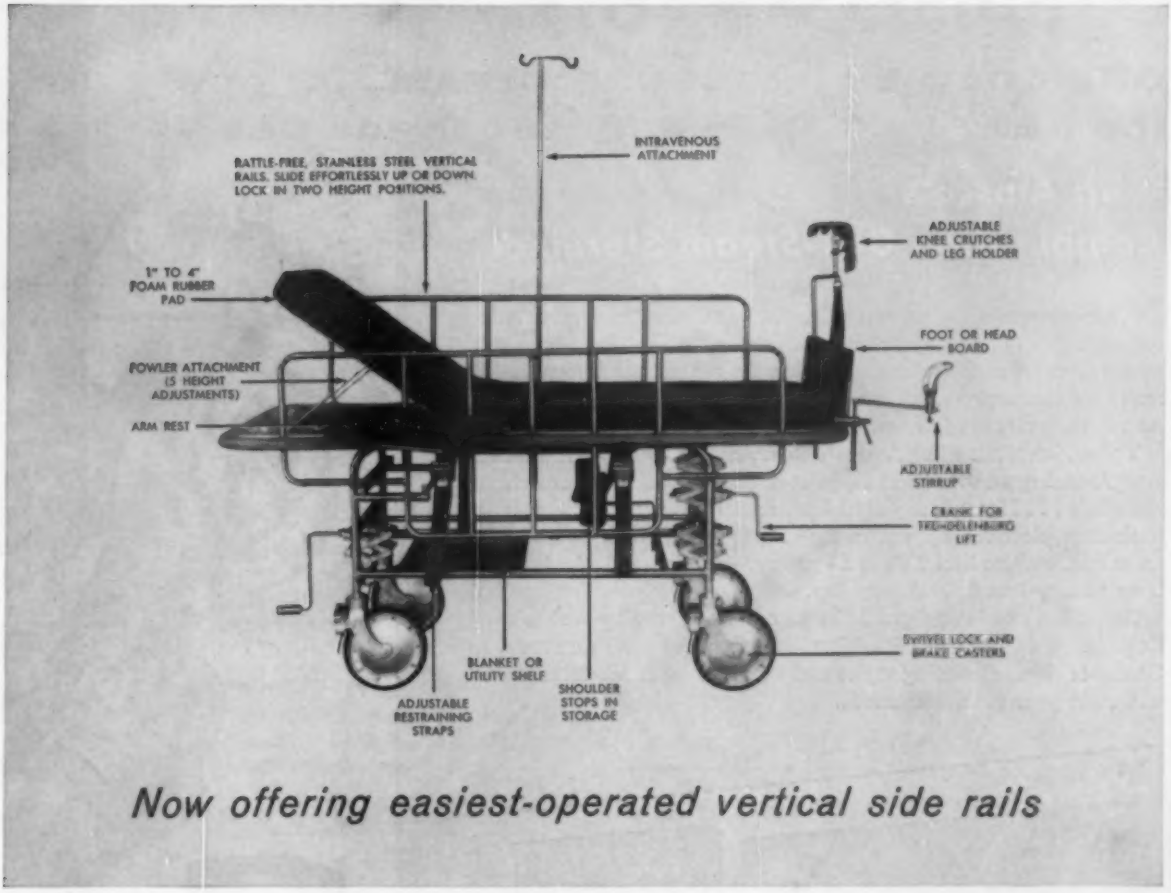

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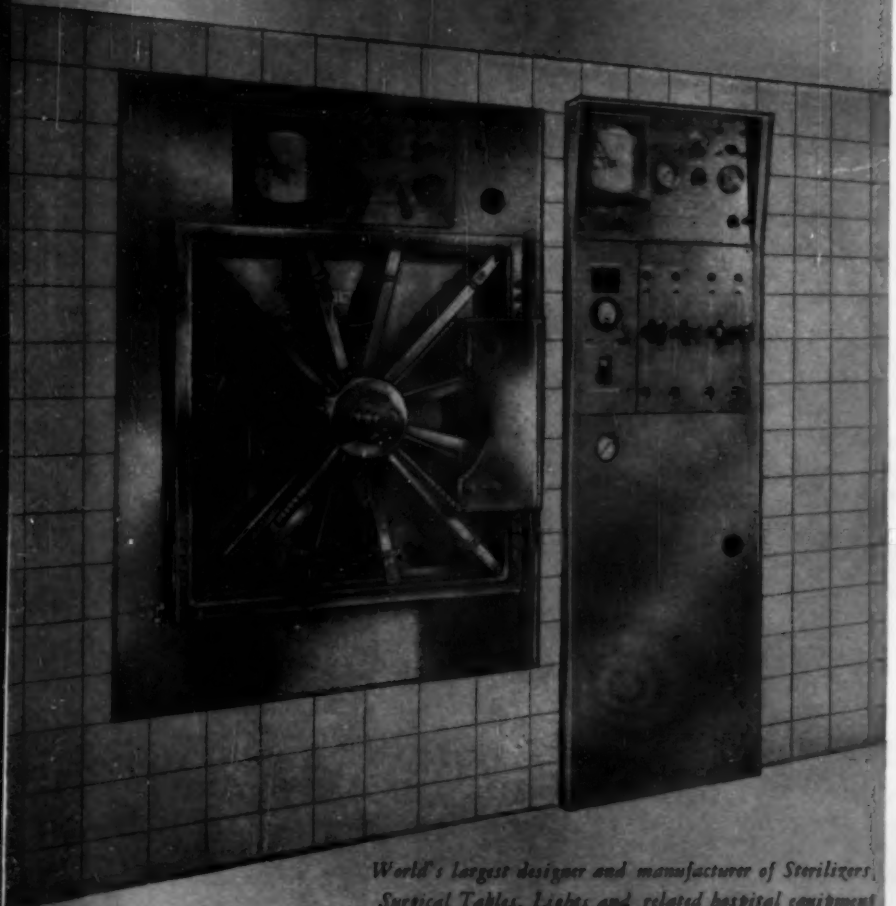

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The Modern Hospital

FEBRUARY 1961 VOLUME 96, NO. 2

Continued on next page ▶

The Modern Hospital

MEDICINE AND PHARMACY

FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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A hospital is more than just beds, operating rooms, x-ray or cardiograph machines.

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READER OPINION

Vendors Could Do More To Help Hospitals

Sirs:

May I express our appreciation for the interesting article which Jane Barton has put together about how our industry serves hospitals ("Dispensing Machines Are Becoming Indispensable," November 1960).

While it portrays the many services which vending machines render to hospital administrators and personnel, your survey certainly also indicates that vending specialists could do a much better job in certain hospitals.

What is really significant from our point of view, and what the article did not bring out as much as other points, is the fact that automatic food and refreshment service as they are becoming available through leading companies in our industry can do a lot more than they have been doing or are doing now for the benefit of the administrator and his staff.

Obviously, too few of our people have yet convinced hospital administrators of this and your excellent survey certainly indicates that we should do a better job of communicating with the professionals who run our hospitals so that we might serve them better.

Walter W. Reed
Director Public Relations
National Automatic
Merchandising Association
Chicago

Why Walk to Wheel Chair?

Sirs:

Hospitals have sometimes been accused, not wholly without justification, of extreme conservatism in adhering to procedures long after the reason for them has ceased to exist — or even after anybody remembers what the reason was.

What may be an example of this was aired last December in the lay press and on television.

The wife of the President was pictured being discharged from a hospital via wheel chair, whereupon she almost immediately hopped up and walked through an extensive tour of the White House, a strenuous undertaking even for a person who hasn't recently undergone major surgery.

Without inquiring into matters that are the private business of Mrs. Kennedy and nobody else's, either the wheel chair was unnecessary or the tour was contraindicated.

Now that a majority of hospital patients are ambulatory and prior to discharge may do everything but work out on parallel bars, why must they still be required to cross the threshold by wheel chair?

It has been alleged that this must be done as the only perfect defense against litigation that could otherwise result if the patient happened to trip over the threshold. Recent legal opinions, however, cast doubt on the validity of this claim.

Is there still a reason for hospitals continuing to insist on discharge by wheel chair? Could it be no more than that it's always been done that way?

David V. Shaw
Hospital Consultant
Chicago

ROVING REPORTER

Iron Curtain Isolates Noncommunist Doctors

Noncommunist doctors in Czechoslovakia are attempting to preserve a Western style of medicine despite the state operated health facilities of the Communist regime. However, the quality of their socialized medical care is gradually slipping behind Western European standards because of their strict isolation behind the Iron Curtain.

This is the impression gained from a firsthand report by Dr. George A. Gruenberg, who recently escaped to the West. Dr. Gruenberg was born and educated in Czechoslovakia and served for six years on the staff of the Clinic of Communicable Diseases in Prague. Other points stressed in Dr. Gruenberg's report follow.

One manifestation of the medical profession's isolation is the scarcity of Western medical journals. Only one copy of the most important U.S. medical journals goes to each of the big clinics and one to the Central Medical Library in Prague. Smaller hospitals or health centers receive no journals. These journals also must pass strict censorship. Medical books purchased by the state usually arrive four or five years after publication. Most doctors are not allowed to participate in international medical meetings, either in the West or in other Communist countries. Even prominent medical school teachers often miss the chance to attend meetings because of "technical difficulties" in obtaining permission to leave the country.

Medical training in Czechoslovakia is comparable to the training given in most Western European universities, requiring five years of intensive medical study and one year of internship. However, the M.D. degree has been abolished by the Communist regime as a "capitalistic asocial distinction of the physician against the working class," and medical graduates now can only sign "Physician" after their names. A "Doctor of Medical Sciences" degree is a possibility for outstanding Party members if they complete fruitful research work.

In general, doctors who are members of the Communist Party enjoy priority over those who are not members. (In rural areas approximately one doctor in 10 is a party member and in urban areas about two in 10.) The better jobs and positions of authority are usually held by Party members.

The official work week for doctors is 48 hours. However, the actual working time often runs as much as 120 hours a week. The reason for this difference between official and actual working hours is the large number of patients each doctor must care for.

All citizens have the right of unlimited office or house calls. Because of this, doctors are overrun by trivial cases and, consequently, the health centers cannot afford time for thorough examinations. The average time spent with a patient at health centers is five minutes. These circumstances cause doctors to refer many patients to the hospitals which can give the patients more time, with resulting overcrowding of the hospitals.

In the largest hospital in Prague, the 3000 bed Bulovka Hospital, one

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doctor must care for 50 patients on his ward. This disproportion in the doctor-patient ratio is caused by the small budgets allocated to health centers and hospitals and by the large number of patients referred to hospitals from the health centers.

Doctors in the health centers are allowed to prescribe only the basic inexpensive drugs. If a doctor prescribes more than he is allowed per patient during the month, the cost of drugs above his quota are subtracted from his salary. This is another reason many patients are unnecessarily referred to hospitals.

In hospitals more expensive drugs, such as antibiotics, are available, but are limited in quantity. There are two factories in Czechoslovakia producing antibiotics, but their production does not meet the needs of hospitals and the imports from Western countries are limited.

No new civilian hospitals have been built since 1940 and, consequently, hospitals are short of beds because the number of people requiring hospital treatment is increasing. When rooms are filled beds are often put in the halls, or even in shower rooms. This bed shortage causes the length of hospitalization to be shortened.

Hospitals are not adequately equipped and spare parts are unobtainable for the equipment that they do have. Modern equipment is known about in Czechoslovakia, but is not available for use in hospitals.

Linen is scarce and often worn out. Sheets are still being used that bear the German eagle and the Nazi swastika.

Hospital food is of poor quality. This is because of the limited choice in buying foods and the prohibitively high prices.

Floor cleaning in hospitals is done by hand; the only machines in use are electric floor polishers. Compound solutions of cresol are widely used for cleaning.

Despite the lack of technical equipment, standards of medical care in hospitals are still much like the care of Western European countries. Many diseases are treated as they would be in the United States: two outstanding examples being scarlet fever and poliomyelitis.

The public health laws are rather strict compared to other European countries. All patients with communicable diseases have to be hospitalized, with the exceptions of measles, chicken-pox, mumps and whooping cough. Vaccinations against all communicable diseases are compulsory from early childhood. Autopsies are performed in all cases without exception.

The maternity service and child care program is rather successful. All deliveries are carried out in hospitals. The average hospitalization period is seven days. Pregnant women receive regular checkups until they are admitted for delivery. The "Well Baby Clinics" give regular checkups to all babies until they are one year old. The infant mortality rate is 31 per thousand (the U.S. rate is 26.4 and U.S.S.R., 45).

A fairly adequate system of blood banks is available for hospital use.

Health care in Czechoslovakia is socialized medicine in its most radical form. However, physicians are attempting to maintain the high standards of Western medicine despite the obstacles of an over-bureaucratized ministry and virtual isolation from the medical profession of the Western world.

Prague Clinic Has Special Balconies for Visitors

The Clinic of Communicable Diseases, Prague, has bed capacity of 500. First floor houses laboratories; next four floors house patients and have balconies for the convenience of visitors. The clinic is 20 years old.

HOSPITALS FACE SPECIAL SECURITY PROBLEMS

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Public May Judge a Hospital by Appearance of Its Publicity

By Gordon Davis

TAKE a look at your literature. I mean really look at it. Spread out on a table or desk as many samples as possible of the printed matter you give to outsiders. Then study it as if you were one of those outsiders, seeking a clue to the nature of the organization that issued it.

Gordon Davis

Are you proud of what you see? Is it wholly consistent with the image of your hospital that you wish to impart to your community? Is it by any chance a little stuffy or dull? Does it appear cheap? Is it confusing, lacking in identity?

Or can you classify it as well done, attractive, friendly, specific, brisk and businesslike, tasteful without being ornate or sumptuous?

How about the paper? Is it crisp and clean, or is it muddy? Is the typography good? What of the illustrations? Are they interesting to nonhospital people? Are they well reproduced? Have you used color to advantage? Are your cover and page layouts well balanced and engaging; or are they cramped, jumbled, unimaginative?

If you were a complete stranger and had never seen your own institution, and if you were asked to characterize it on the basis of its printed materials, what would be your judgment?

This last question is, after all, the essential one. **Printed material not only informs; it also creates impressions. Indeed, its appearance creates impressions even if the text is not read, and this subtle, subconscious communication can have much to do with your community's attitudes.**

An institution expecting the people to entrust their lives to its care cannot afford to have it appear that its standards are low in any department.

The real cost of literature is seldom in its duplication. It's in its preparation — the writing of the text and the development of layout and illustration. It is also in its discard rate, the extent to which a given piece is thrown away without being read. Visual stodginess that elevates the discard rate can be expensive.

Like most of the tools of public relations, printed matter should be analyzed for its intended mission before the work of production begins. If it is to be circulated only to department heads and supervisors, a straight job of mimeographing can do. But if it is to do a public job, such as welcoming incoming patients, it must be well done — carefully thought through, warm in color and content, friendly, immaculately printed.

There is value, too, in establishing some sort of common denominator that will identify most of your printed pieces at a glance. One hospital accomplishes this by reproducing most of its literature on a beige paper in dark brown ink. Others have a standing signature or logotype or some other symbol, like the seals and trade-marks of business. Some use certain standard type faces or formats.

This establishing of visual identity can help overcome the confusion of myriads of pieces, each looking as though it came from a different origin.

Make your printed matter speak well of your hospital. It's a low-cost building block in your public relations structure. ■

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Here's your fluoroscopic dream made a clinical reality! With the Fluoricon image intensifier you can far outstrip yesterday's concepts of fluoroscopy, reading easy-to-see images thousands of times brighter and far more detailed than those of conventional fluoroscopic screens. And you view *comfortably*, with both eyes, thanks to the new General Electric optical system.

Fluoricon also offers you perfected and simplified cinefluorography. You can trigger rapid-sequence runs instantly, any time you choose . . . with reliability that makes it truly an *everyday diagnostic tool!*

You can even add television, vastly increasing your capacity to accommodate observers *without* crowding your work area. Simply locate monitors wherever convenient.

This just begins our Fluoricon story. See the following pages for more details of its many operating features and advantages.

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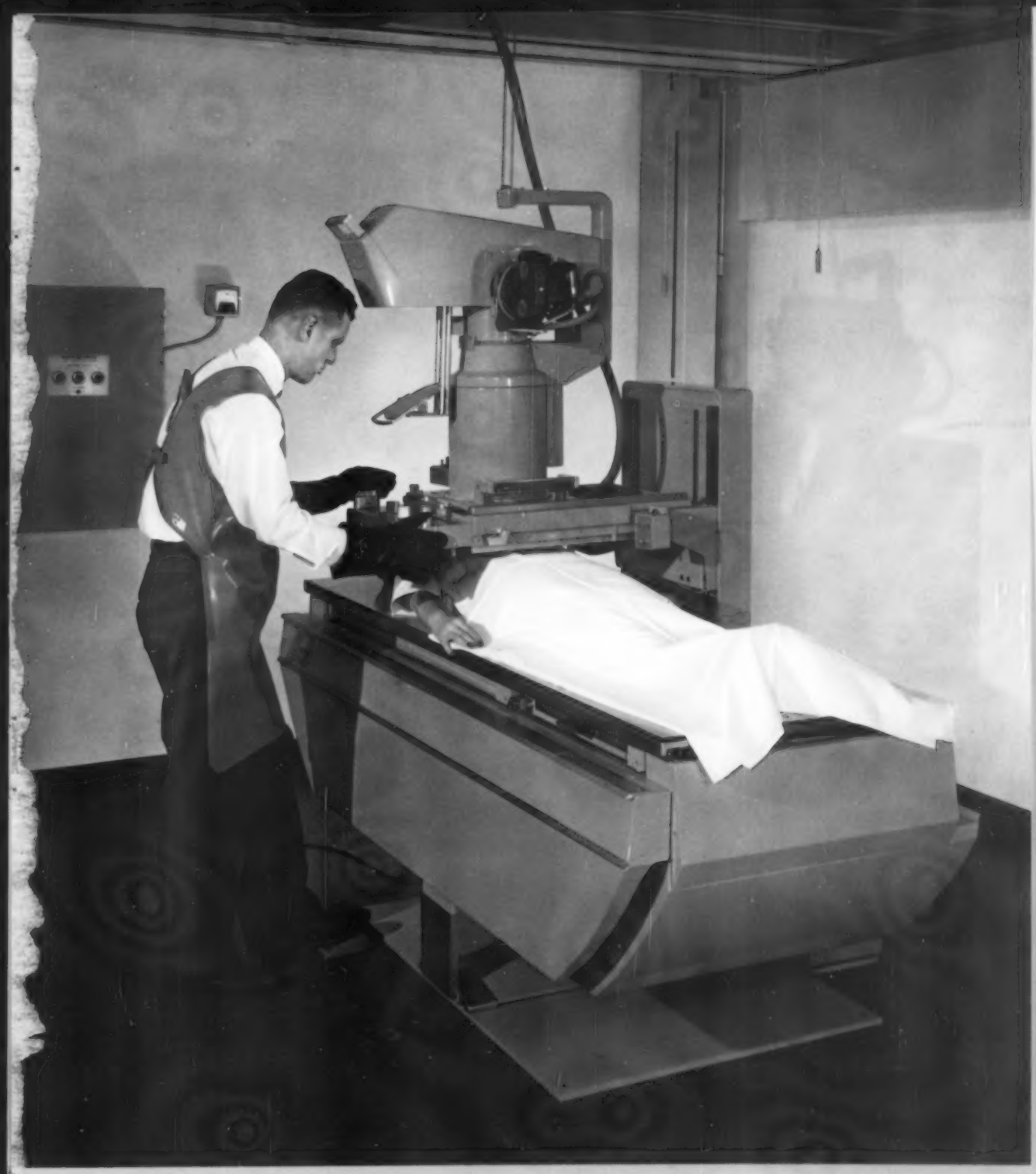
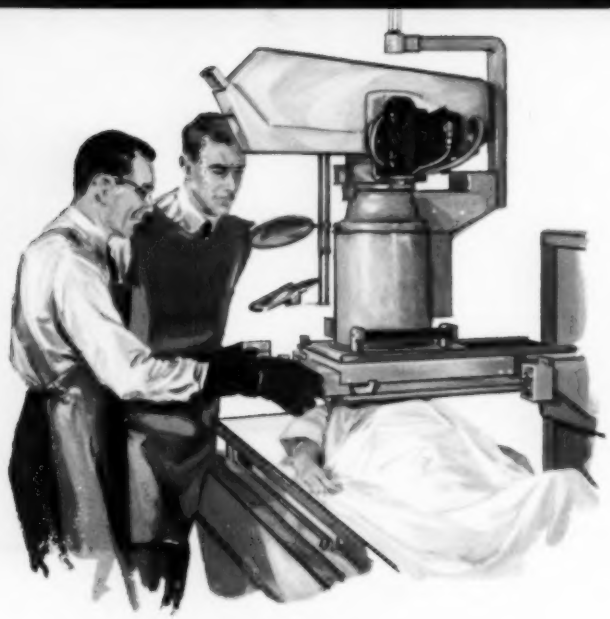
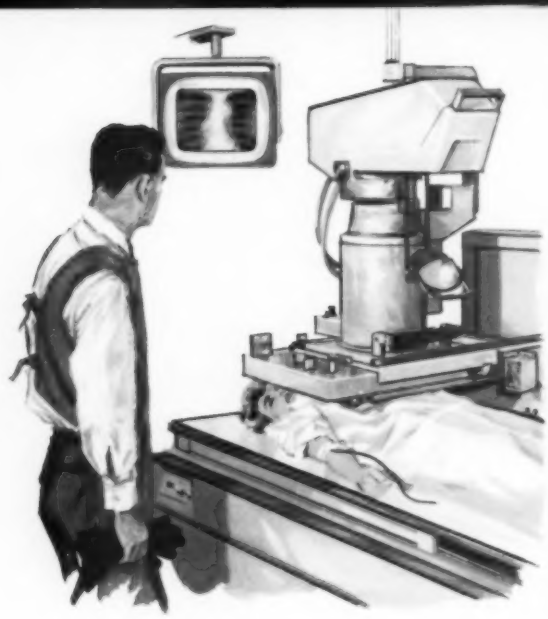
Companion cine cameras make high-speed recording as easy as spot-filming!



General Electric Fluoricon image intensifier. Compact silhouette requires less clearance than any other typical system (an 8-foot ceiling is ample). The Fluoricon is shown here on the recently announced G-E Monarch x-ray table.





Your choice of image tubes

Select from a variety of performance characteristics —with tubes of 6, 7 and 9-inch field size. You can have brightness ranging to 3000 gain, ideal for high-speed cinefluorography . . . or choose exceptional resolution and contrast with a 1000-gain factor. Easy-view, full 4-inch exit pupil (compares with 2¾-inch typical interpupillary span). Two can view simultaneously simply by attaching beam-splitting consultation mirror.

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Add large-group viewing capacity to Fluoricon without adding bulk! Closed-circuit TV monitors can be placed wherever you want them. Camera has sensitivity surpassing the naked eye . . . hides out of sight inside Fluoricon optical hood, always ready for use when you need it. A particular asset for resident training programs.

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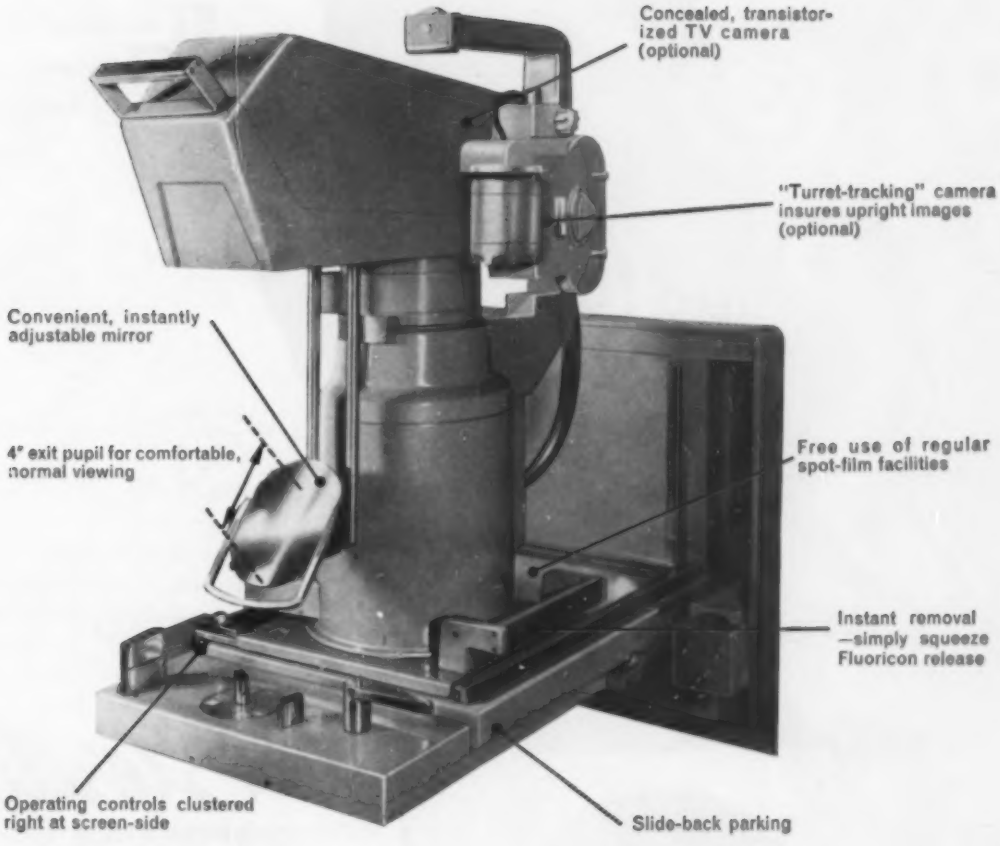

.....everything you need to command ultra-modern image intensification!

Feature by feature, the General Electric Fluoricon reveals advanced standards of image quality, achieves a new flexibility in cinefluorography. Much of its sophistication stems from the exclusive G-E optical system with f/1.0 (90 mm) objective lens.

For synchronous filming, General Electric's *Aerial Camera specialists* have created a completely new camera, solely for cinefluorography. Their experience with specialized photographic instruments is reflected in the compact design and precise operation of this cine camera.

With it all, Fluoricon still rivals conventional fluoroscopic devices in operating simplicity. It's a genuinely *practical tool*—designed for the most demanding applications.

Ask your G-E x-ray representative about the FLUORICON. Or write to X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for a copy of Pub. 1102R.

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on the pathogenesis of pyelonephritis:

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The "exquisite sensitivity"[2] of the medulla to infection (as compared with the cortex), highlights the importance of obstruction to the urine flow in the pathogenesis of pyelonephritis. "There is good cause to support the belief that many, perhaps most, cases of human pyelonephritis are the result of infection which reaches the kidney from the lower urinary tract."[3]

to eradicate the pathogens no matter the pathway

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High urinary concentration • Glomerular filtration plus tubular excretion • Rapid antibacterial action • Broad bactericidal spectrum • Free from resistance problems • Well tolerated—even after prolonged use • No cross resistance or cross sensitization with other drugs

Average Furadantin Adult Dosage: 100 mg. tablet q.i.d. with meals and with food or milk on retiring. *Supplied:* Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. 102:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. 30:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. 30:341, 1958.

NITROFURANS—a *unique* class of antimicrobials

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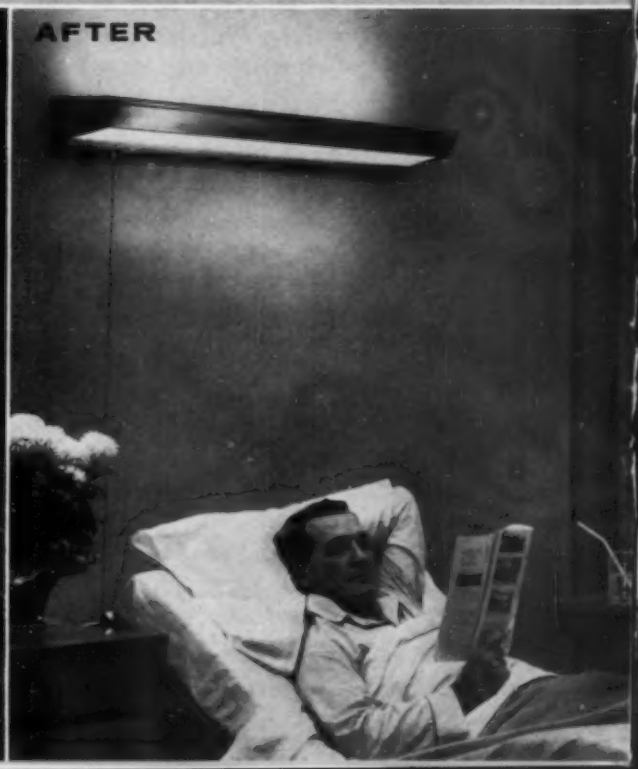
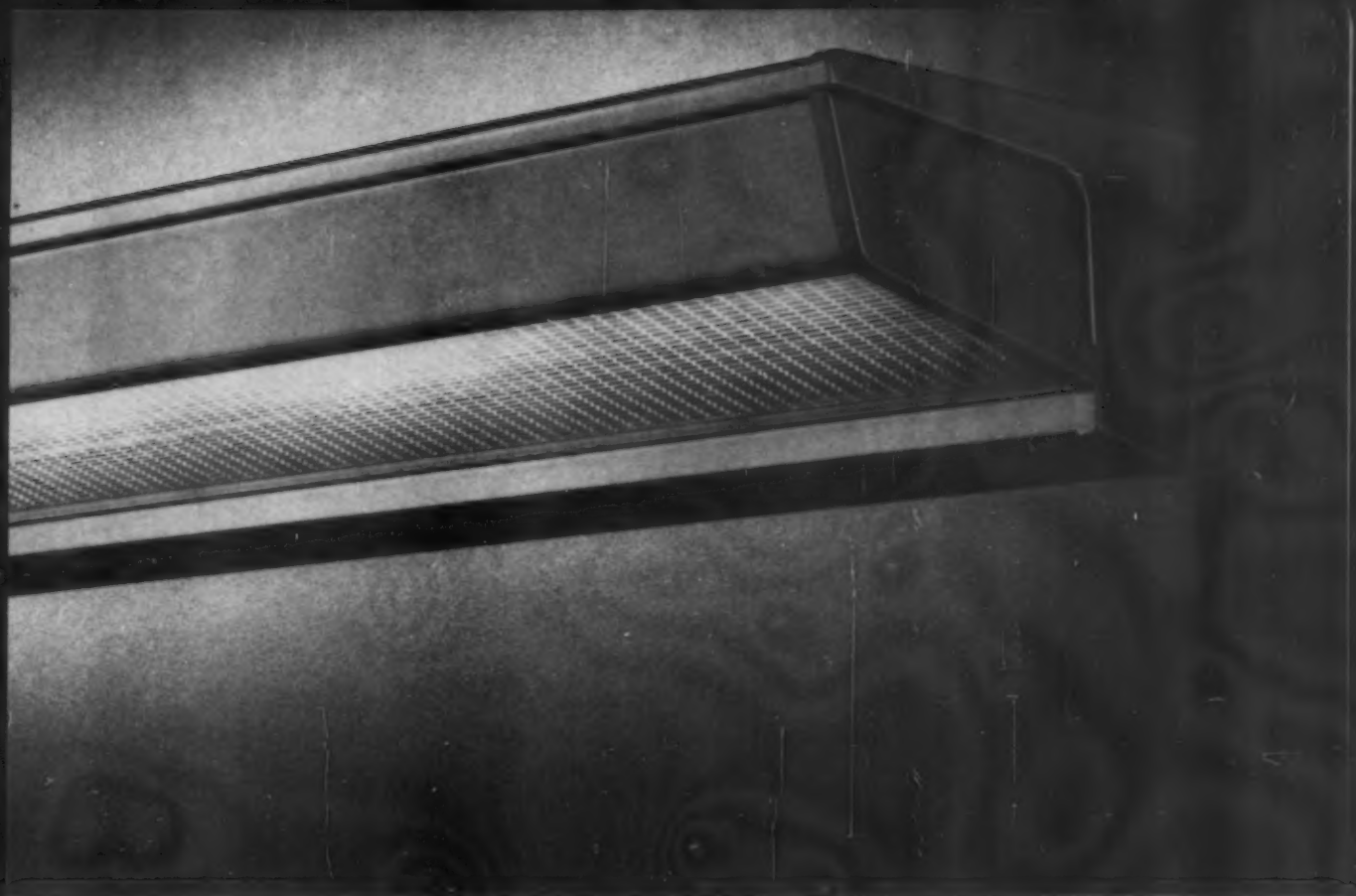
See the difference TRANQUILITE makes in transforming a cold, harshly-lighted hospital room into an attractive, modern setting. Patients look better, see better . . . even feel better!





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- Switching provides reading light, night light and general illumination
- Convenient electric outlet for examining light, electric razor or radio
- No annoying glare . . . ideal for multiple-patient rooms and wards
- Available in 2 or 4-foot lengths, stainless steel or baked white enamel finish

First time you see it you'll know that here's a behind-the-bed fluorescent hospital fixture worthy of the Day-Brite name—with the clean lines and quality look you expect from America's first name in lighting equipment.

But only when you have seen it **in action** can you fully appreciate what an amazing difference TRANQUILITE makes. Cold, clinical-looking hospital rooms take on new warmth . . . become more inviting. In older rooms, TRANQUILITE's soft illumination hides defects . . . adds a modern touch.

TRANQUILITE is just one of a complete line of "Decidedly Better" Day-Brite fixtures for every hospital need. All are/**easy to install/ easy to clean/easy to maintain.** Get the full story from your Day-Brite representative, or write: **Day-Brite Lighting, Inc., 6260 N. Broadway, St. Louis 15, Mo., and Santa Clara, Calif. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ont.**

DAY-BRITE

NATION'S LARGEST MANUFACTURER OF COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT

What HIGH VACUUM Sterilization can mean for your hospital

by Richard D. Castle

NO. 1 IN A SERIES

This is the first in a series of articles on High Vacuum Sterilization. Its purpose is to examine the significance of this new process. Its author is Richard D. Castle, head of Research and Development, Wilmot Castle Company, Rochester, N. Y. Working with the Drayton Regulator & Instrument Co., Ltd., Castle has developed the OrthoVac* High Vacuum Sterilizer, first models of which will be installed this year in U. S. hospitals.

● The concept of High Vacuum Sterilization was first developed by scientific interests in England. In a research project to evaluate the best system of sterilization for use in a national hospital modernization program, both the continental "partial vacuum" system of air removal and our own concept of "downward displacement" were studied. Both were found deficient. The high vacuum system has since been adopted as the national standard in England.

● We feel most fortunate in being associated with one of the early participants in this program—the Drayton Regulator & Instrument Co., Ltd., of England. Drayton's high vacuum controls are today recognized as the industry standard and the company has already converted over 200 English installations to the high vacuum system.

● The same problem the English have faced and begun to eradicate exists in this country today—namely the inability of the conventional sterilizer to assure efficient, totally effective air removal under all conditions.

● Air, of course, acts as a barrier to steam penetration, slowing and sometimes even preventing the attainment of bactericidal conditions. Under present systems, the speed with which air can be removed, and the certainty of its removal, depend almost entirely upon the size and density of the individual sterilizer load, as well as the manner in which packs have been wrapped and placed in the sterilizer.

● In a test, four seemingly identical packs were placed in varied positions in the chamber of a sterilizer. One reached sterilizing temperature in 5 minutes, another in 25 minutes, with the third and fourth falling in between. Since there has been no way to accurately estimate the time necessary for air removal and heatup in any given case, only gross approximations of overall sterilizing time have been applicable, and these only with addition of ample and varying safety margins. Under these circumstances, it is not surprising to find one hospital routinely sterilizing dry goods for 30 minutes at 250°F, another for 60 minutes, and still another for 90 minutes. Standardization, with the safety and efficiency it brings, has been impossible.

● With the advent of the newly-developed Castle-Drayton OrthoVac High Vacuum System, however, such standardization becomes feasible in this country for the first time.

● *The OrthoVac System utilizes a high-efficiency vacuum pump to draw a near-absolute vacuum in the sterilizer before steam is introduced. So effective is this removal that steam penetration and load heatup are practically instantaneous. Absolute uniformity of temperature is obtained throughout the load within a predictable period. The result is sterilization which consumes far less time, incurs less damage to goods processed, and reduces the process to mathematical certainty.*

● Certain essentials, we have found, are necessary to make the system practical under hospital working conditions. First, the vacuum system used must remove enough air so that no variation in the time necessary for steam-air interchange occurs. This requires a vacuum of less than 20 mm absolute. Furthermore, the vacuum system must be controlled so as to produce precisely the same degree of vacuum during each cycle. To accomplish this, we are using a compensated absolute pressure switch which automatically maintains a precise pre-set degree of vacuum during each cycle, regardless of barometric pressure fluctuation or height above sea level.

● Secondly, to standardize procedure and eliminate possibility of error, a device known as a time-temperature integrator is essential. This device automatically and continually adjusts the exposure period to reflect the temperature in the load, following established thermal death curves. Human error in temperature selection is avoided, fluctuations in steam temperature are automatically compensated for, and the load is exposed to temperature for the minimum time necessary for kill through use of this device.

● Aside from the increased safety of the process, a number of other significant contributions are made by the OrthoVac High Vacuum System.

● A typical "dry goods" cycle takes just 15 minutes from beginning to end, compared to the present-day 60-90 minute cycles. By drawing a "post-vacuum" at the end of the cycle, residual moisture is "boiled" away under reduced pressure and the load returned to its original state of dryness. This not only accelerates drying, but cools by evaporation so that the load may be handled comfortably.

● Owing to the much shortened overall cycle and the virtual absence of air, fast-killing temperatures up to 275°F can be routinely used for fabrics, with considerably less deterioration than by conventional methods.

● Sterilizers may be loaded to capacity—an increase of approximately 25% for every existing "dry goods" sterilizer.

● More effective air removal increases, too, the number of items which can be sterilized in steam. Small bore items such as capillary tubes, needles and goods packaged in permeable material such as paper, nylon autoclave film or cardboard containers, formerly difficult or impossible to sterilize in steam, may now be routinely processed.

● *First production models of the OrthoVac Sterilizer will be installed in hospitals this year. Based on Drayton's experience in England, we have developed the OrthoVac System as a control console which, in many cases, will permit on-the-job conversion of existing "downward displacement" sterilizing equipment. The console design, we feel, will allow hospitals to convert present sterilizers to the safer, more efficient high-vacuum system without spending the additional funds necessary to purchase a complete new sterilizer, or altering present sterilizer facilities to accommodate additional sterilizing equipment.*

How DennisonWraps make major contributions to
Efficiency of Autoclaving Procedures

Better utilization of time and space **is the constant goal of all Central Service Departments. If you're interested in measuring the efficiency of your autoclaving operation, the following questions and answers bring out valuable information.**

Q. *Why do you stress the importance of rapid drying when you compare muslin with DennisonWraps?*

A. Because DennisonWraps dry approximately five minutes faster than muslin, busy central service departments have reported an extra autoclave load per day. This faster drying feature also has a safety aspect. You may have noticed that packages removed from the autoclave often feel warm and moist, indicating the presence of steam inside. Sudden exposure of such packages to the cooler room temperature raises the possibility of condensation and contamination.

Q. *What difference does it make whether I get muslin wrappers from the laundry or DennisonWraps from the storeroom?*

A. The difference is that YOU have efficient control of your wrapper supply at all times. When you have one case of DennisonWraps in use and one in reserve, you will never run out of wrappers. Your aides and your autoclave are always efficiently employed.

Q. *Why do you say that the non-bulky nature of DennisonWraps will increase Central Supply efficiency?*

A. First, consider your storage problem. You can store three times as many DennisonWraps as muslin wrappers in a given area. The more you can store, the safer your reserve supplies.

Then, too, packages wrapped in DennisonWraps are much more compact than those wrapped in muslin. This is particularly noticeable with small items like powder packets and medicine glasses. You'll agree that you can autoclave at least 25% more per load. The more you can autoclave at one time, the greater your efficiency and the lower your cost. And you can store 25% more in a given shelf space, too.

Q. *Why do you claim that DennisonWraps increase inspection efficiency?*

A. Muslin is so porous that it must be used in two layers. So, both layers must be inspected. Only the provision of good lighting from above and below will disclose broken fibers in the muslin. Since you need only one thickness of DennisonWraps for safe sterilization and storage, double inspection is unnnecessary.

Q. *Why do you say that the switch from muslin to DennisonWraps would reduce teaching time?*

A. Because you'd be teaching a familiar technique. Every new aide knows how to wrap gifts and parcels in paper. None has ever used floppy muslin as a wrapper. So, you need only show the prescribed wrapping techniques employed in your hospital.

Q. *Doesn't the stiffness of paper make wrapping more difficult?*

A. Not with DennisonWraps. Remember, they're double-creped to produce a ribbed texture. Because of their two-way stretch, they retain their shape when folded. No need to hold them firmly to prevent them from sliding out of position as with muslin.

Q. *How would you sum up the major differences between wrapping with muslin and with DennisonWraps?*

A. Increased efficiency all along the line. Your wrappers are always under your control. Since you need not unfold each sheet of DennisonWraps, you eliminate a whole series of costly motions. Moreover, it takes less time to wrap an article in paper than in muslin because folds do not slide away from aides' fingers. And, finally, because you have the right pre-cut size for each package, no time is lost folding under excess bulk as there is with muslin.

Q. *What's the most efficient way to get started with DennisonWraps?*

A. Get a free hospital evaluation kit and use it to conduct comparative tests. It contains DennisonWraps in the most-used sizes and forms: sheets, glove wicks, envelopes and cases, plus hospital reports on the safety, economy and efficiency of DennisonWraps. Ask your local hospital supply house . . . or address your request to Dennison Manufacturing Co., Dept. P 9, Framingham, Mass.

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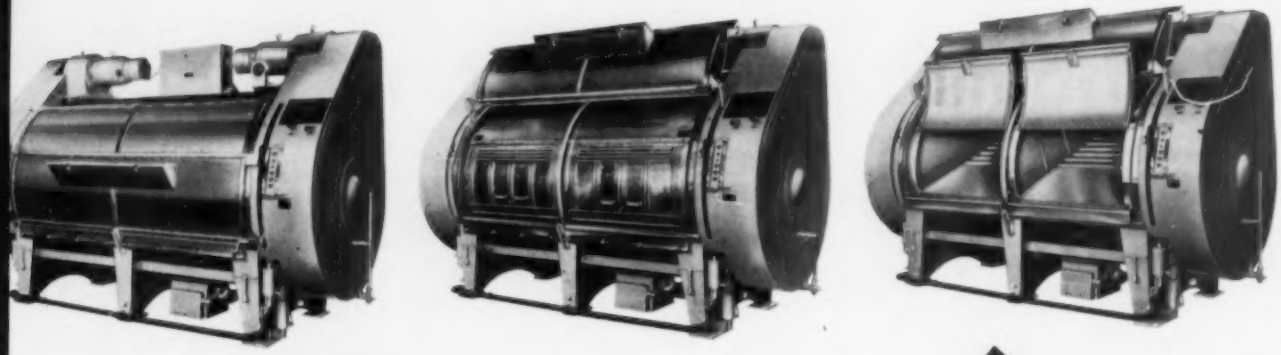

LO-DOOR

Any way you like to figure it—volume of work per load . . . or production per square foot . . . or investment per pound capacity . . . or cylinder capacity per linear foot of washroom gutter—the Lo-Door Mammoth Cascade Washer proves out every time to be your best big-volume buy.

And think of the convenience! The low-set tub doors and sloping horizontal or "Y" partitions make unloading fast and easy, save labor, reduce strain on both operator and work. The tub door can even be air-operated if you like, for push-button operating ease.

You'll like the Lo-Door Mammoth Cascade because—load after load—it's the most productive big-volume washer you can buy! Two sizes; 60x96″ (900 lbs.) or 60x126″ (1200 lbs.), horizontal or Y-partition cylinder.

Call your nearby American representative for complete information, or write today for illustrated catalog AB 337-202.

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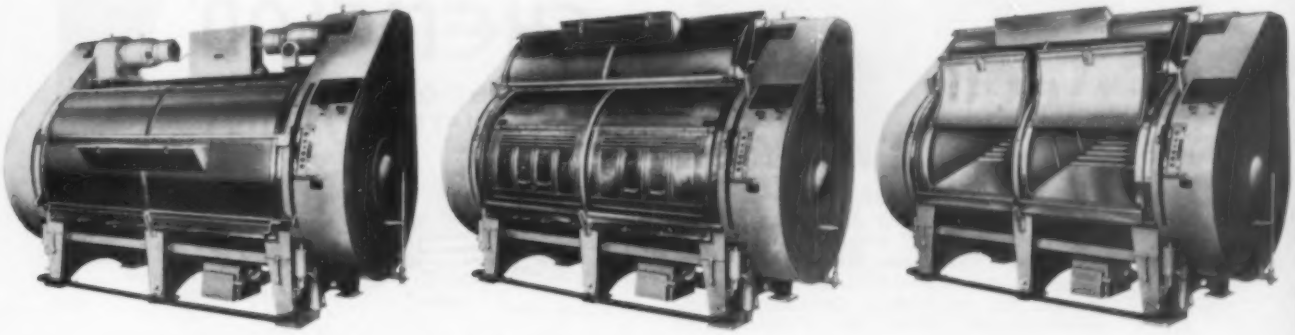
Cascade is the most productive big-volume washer you can buy!



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Conductive Flooring alone *cannot* prevent fire and explosion.

The sad fact is tragedy may strike even in Operating Rooms, Laboratories and other sensitive areas "protected" by such floors. On-the-spot investigation invariably reveals that the fault lies *not* with the construction of the floor itself—but with *improper maintenance.*

Dirt, fatty soaps and most waxes insulate the conductive surface, pushing resistance readings sky-high.

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LEADING MANUFACTURERS OF CONDUCTIVE FLOORS SPECIFY LEGGE MAINTENANCE EXCLUSIVELY

Congoleum-Nairn, Hubbellite and other makers of Conductive Flooring recommend LEGGE maintenance materials and methods for all hospital and industrial installations. LEGGE Polishes and Cleaners *retain* conductivity. Your LEGGE representative has been schooled by the firm that has crusaded for Conductive Safety for a quarter-century. Under his guidance, your porters learn the complexities of electrostatic hazards. He'll map out a daily program of upkeep; take frequent resistance readings; keep your floors functioning safely within the prescribed limits of NFPA and other Codes.

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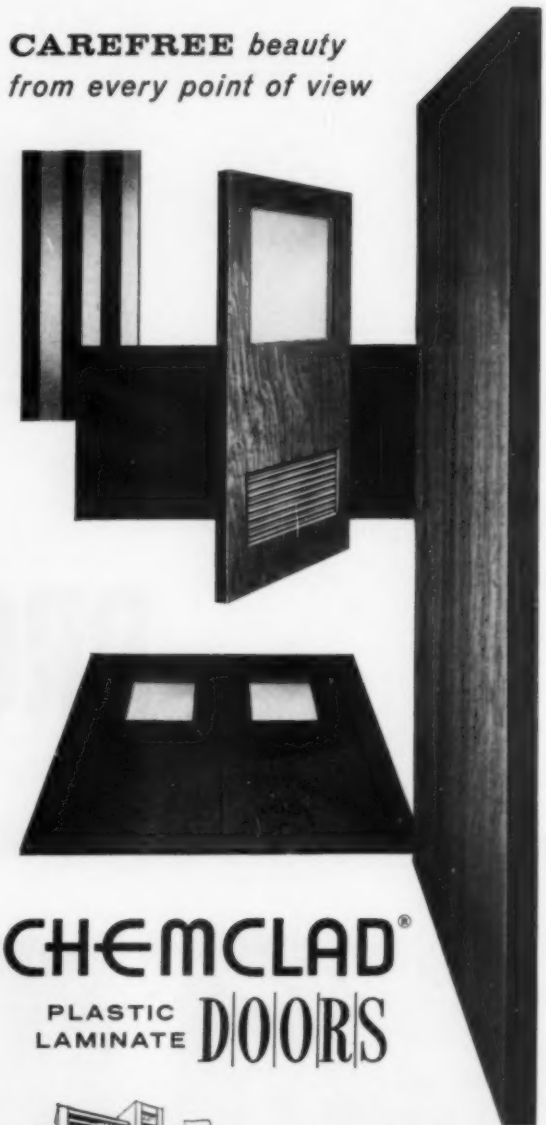

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1,256 custom made Chemclad doors have been installed in the Schumpert Memorial Hospital, in Shreveport, Louisiana. Architect: Neild and Somdal.

From both a practical and aesthetic point of view, custom-built Chemclad Doors offer many advantages for commercial and institutional buildings. The beautiful, rugged plastic laminate faces and edges come in a wide range of wood grains and decorator colors with either furniture finish or parchment textured surfaces. Carefully built to your exact design, they retain their good looks for a lifetime with low cost, minimum upkeep. Write for complete details on Chemclad Doors *and* Partitions. *See us in Sweet's.*

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St. Mary's Hospital, Gates Memorial, Port Arthur, Texas.

"PURITAN ENGINEERED MAINTENANCE made our housekeeping and sanitation efforts 5 times more effective!"

Before developing the program, Puritan made a complete survey of the hospital. J. E. Treaster (r) confers with the Puritan representative as the survey is begun.

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Thorough "how-to" training gets maximum effectiveness out of each housekeeping operation. This training also makes important contributions to efficiency.

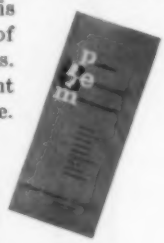
Regular inspections by the Puritan representative assure that the new standards, set by the ENGINEERED MAINTENANCE Program, are being maintained.

"With an old building and an unorganized housekeeping staff," says J. E. Treaster, Director of Sanitary Maintenance at St. Mary's, "we thought we'd never be able to achieve the kind of sanitation and housekeeping that would satisfy us."

"We finally decided to see if Puritan ENGINEERED MAINTENANCE could bring about some improvement. What it did bring about was more of a revolution—one that actually increased the effectiveness of our housekeeping and sanitation efforts 500%, doubled the efficiency of these operations, and made important contributions to our safety program."

"In addition, the morale of our housekeeping staff is now the highest in the hospital. And no group is more gratified with the improvements made by Puritan ENGINEERED MAINTENANCE than our medical staff."

Puritan ENGINEERED MAINTENANCE is a complete sanitary maintenance program and consulting service, tailored to your specific needs. It is available, *without charge*, to users of Puritan sanitary maintenance products. As a hospital executive, you will want to know more about this unique service.



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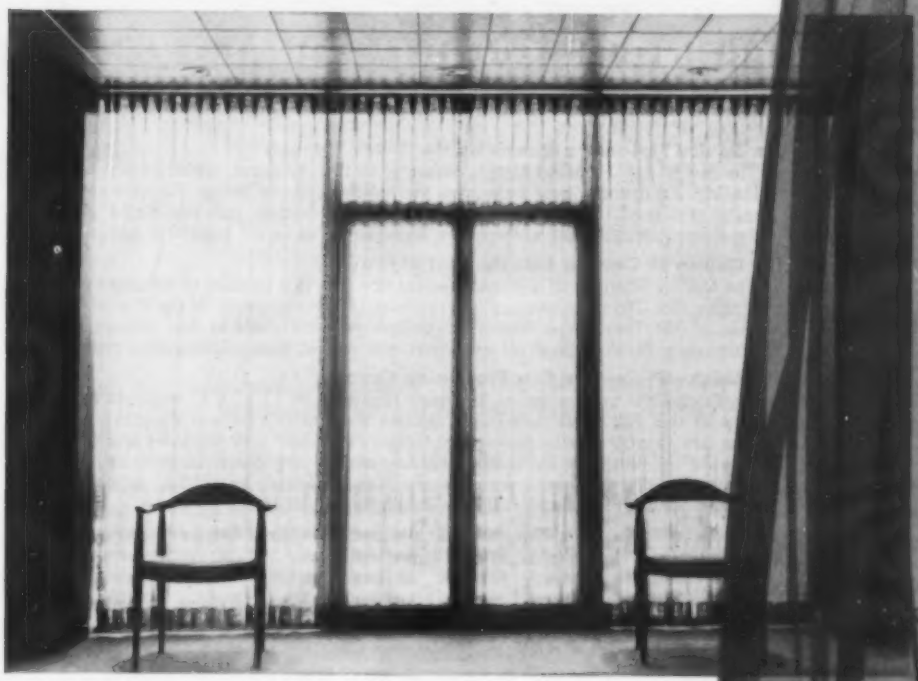

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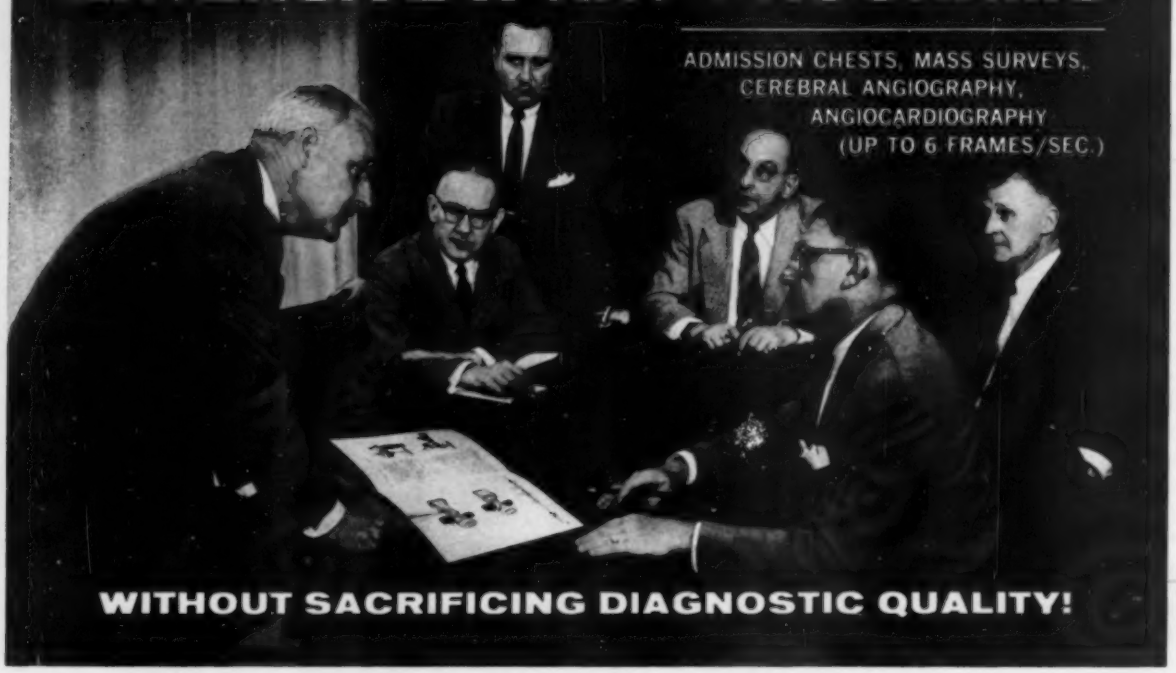

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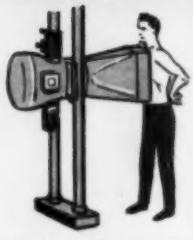

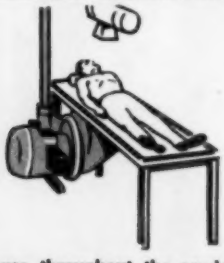

The Odelca PF Camera Speeds Up the X-Ray Process.
The new 4" x 4" (100mm) camera makes up to 100 exposures, automatically, at one loading. An operator need only press the X-Ray exposure button. Errors automatically prevented. Unfailingly-accurate film identification assured. Rapid Roller Separator cassette takes a 40-picture sequence at up to six exposures per second.

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The Odelca 70mm or 4" x 4" cameras cut film cost to a fraction of full-sized radiographic film – from an average 72¢ to about 10¢ per exposure for the 4" x 4", even less for the 70mm! An Odelca PF camera pays for itself in film savings alone (after only 10,000 exposures) – in about one year in most medium-sized hospitals.

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An Odelca PF camera makes 24 70mm negatives, or 12 4" x 4" negatives for the cost of one full sized radiograph, figuring the cost of film and chemicals alone. The labor saving is even greater. An Odelca "Procator" unit processes fifty 4" x 4" films at one time. Special hangers holding nine 4" x 4" films can be used in your regular X-Ray solution tanks. For the 70mm camera, an Odelca motor-driven "Hansen" unit processes roll film in lengths up to 100 feet.

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4-5 times faster than refractive lens cameras, reduces radiation exposure 75-80%.

Revolutionary in concept. Exceptionally super-speed Bouwers' concentric mirror optical system produces negatives of highest diagnostic quality. All Odelca cameras fulfill the Chantraine condition–under six times magnification you can easily distinguish the elements of a 60-line grid on an Odelca negative – diagnostic quality no refractive lens camera can approach!

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Above is the "backbone" of a Patient-Safety Program... an experienced Huntington representative and 108 high quality sanitation products. His experience and these sanitation specialties, developed by Huntington's research laboratories especially for hospital use, provide the flexibility to meet the aseptic requirements of every hospital. Turn the page and read how Huntington can help you prevent hospital-acquired infection in your hospital.

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The Huntington Patient-Safety Program

How to prevent infection from originating in the hospital. That's the problem. Many hospitals are solving it by returning to old-fashioned attitudes toward cleanliness in every department combined with the use of modern, efficient aseptic products. And they are adopting the basic principles of a Patient-Safety Program to set up a common-sense plan-of-attack against resistant Staph. and all other infectious agents.

This practical program features:

- More than 100 Huntington products that will effectively help combat the spread of infection from the admitting office to the O.R. suite, the nursery, everywhere in the hospital.
- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

Call or write today. Get more details on the Huntington Patient-Safety Program.

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- ☐ Send data on Spal Concentrate soapless detergent.
- ☐ Send more information on Contrast Floor Polish.
- ☐ Have your representative call for an appointment.

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There's no fine print in Onan's pricing policy!

'Strip-downs' and 'price-adders' are getting out of hand in the electric plant industry. There have always been a few who have sold strictly on price, and of course, got the price down by stripping equipment of essential components.

Today, some leading manufacturers are stripping-down their electric plants.

These stripped-down prices *are* attractive. But when you add the cost of such essentials as oil and water pressure gauges, battery-charging ammeter, over-speed shutdown, radio suppression, flexible exhaust tubing—*even mufflers!*—what happens to your bargain price? You're right—you wind up paying more.

Onan has never produced a stripped-down model, has never used essential operating accessories as 'price-adders.'

Today, more than ever, it will pay you to go over electric plant prices with an eagle eye. *Compare Onan prices with others before you buy.* (But read the fine print.)

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Fresh, appealing wall beauty...minimum maintenance, with year after year freedom from repairs and redecorating...effective crack prevention and concealment...high mar resistance and maximum fire protection...

New York Life obtained all these, plus long-term economy, when it chose *Vinyl "Fabron"* for all corridor walls of the two new 21-story Lake Meadows apartment buildings shown.

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Est. 1913...Oldest and Largest in Permanent-Type Wall Coverings

Quixams®: Made for Emergency Room Economy

Every easy-on-and-off Quixam fits either hand; saves sorting and handling time; reduces costs where usage is greatest. Quixams are only one of the complete line of PIONEER Rollpruf Surgical and Hospital Gloves — all designed for positive savings on specific jobs. A PIONEER Glove Expert can help you save by making a complete analysis of your glove problems.

Free Glove Handling Analysis

Requested by_____

Title_____

_____ Hospital

City_____ State_____

The **PIONEER** Rubber Company · 350 Tiffin Road · Willard, Ohio

For additional information, use postcard facing back cover.

How *Imaginative Engineering* Put Taming Chicago's

John Dolio (right) in front of Powers Graph-O-Matic Control Panel with E. S. Anderson, engineer for the Illinois Psychiatric Institute.

The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort —even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes —the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.

Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Powers Temperature Control To Work Weather At Illinois Psychiatric Institute

Illinois Psychiatric Institute
Chicago, Ill.

Illinois Supervising Architect:
Louis H. Gerding
Architects:
Shaw, Metz & Associates, Chicago
Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth
Consulting Engineers:
John Dolio & Associates, Chicago
Heating, Air Conditioning Contractor:
Gallaher and Speck, Inc., Chicago
Ventilation: Zack Co., Chicago

JOB DETAILS

The system encompasses 12 temperature zones, each designed to operate independently in relation to individual zone exposure problems. Ten zones utilize ceiling heating and cooling panels at which hot and chilled water circulate from zone exchangers. Three-way control valves for the water are modulated by pneumatic thermostats in various rooms. Two zones — auditorium and stairwell — have only heat exchangers (the auditorium is supplied with individual conditioned air).

Master outdoor controls sense the changes in temperature outdoors and instantly reset submaster pneumatic thermostats at the zone exchangers. These indoor-outdoor controls are engineered for foolproof maintenance of uniform zone temperatures.

A central control board, the heart of the Dolio design, monitors the complete heating, cooling and ventilating system. The building engineer alone can instantly check 170 control points by merely referring to the Powers Graph-O-Matic Control Panel.

Temperature controls are inaccessible to patients. All controls in the corridors are wall-mounted and cabinet-enclosed; temperature sensors are mounted in ceiling exhaust ducts.

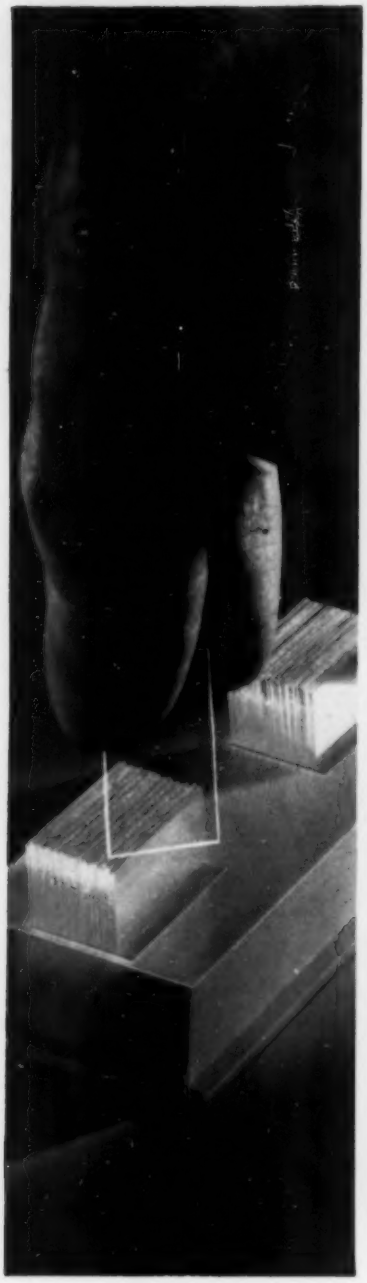
Easy servicing and low maintenance are two big reasons why a pneumatic system of control was specified by this engineering firm. Efficiency at low cost is characteristic of this type of control — as it is with the Powers pneumatic system installed here.

Safety and comfort for patients is provided for throughout. For example, in hydrotherapy, in showers, in sitz baths, etc., Powers Hydroguard® thermostatic water controls prevent scalding and eliminate dangerous water temperature fluctuations.

Write for the latest Powers Hospital Catalog.
Write us also for catalog on time-saving, money-saving pneumatic tube systems manufactured by our new subsidiary, the Grover Company.

THE POWERS REGULATOR COMPANY
DEPT. 261, — SKOKIE 57, ILLINOIS | *Offices in Principal Cities in U.S.A. and Canada*
MANUFACTURERS OF THERMOSTATIC CONTROLS SINCE 1891

HOW IMPORTANT IS PRICE



When you look at prices on cover slips, consider the special dispenser you get with CORNING cover glass. The glass is clean; often you can use it right from the box. It also makes for cleaner, faster handling.

When you look at prices on graduated cylinders, consider the extra strength you get with PYREX graduates. That shoulder under the rim takes the shock of an upset, prevents the rim's striking the bench. The markings are permanent. They're etched through a layer of red glass.

When you look at the prices on culture tubes, consider the time our screw cap models can save. You eliminate cotton plugging, media stay lint-free. The caps are tough, stand up to heat and steam. White, inert rubber liners last the life of the tube.

IN BUYING LABWARE?

When you look at prices on centrifuge tubes, consider the extra strength built into PYREX tubes. The ends are accurately formed and uniform to take the strain of centrifuging. The permanent graduations of this ACCU-RED model are applied without etch marks in the glass, which often weaken centrifuge tubes.

When you look at the prices on pipets, consider the extra life of the markings on our ACCU-RED pipets. The marks are built into the glass, last as long as the pipet. There are no etch marks to weaken the glass. No fillers to wear off or fall out.

It's an unfortunate fact that a purchaser cannot determine the *cost* of labware simply by holding it up against a scale of *prices.*

Check your own experience and you'll find that, although two brands of the same item may be *priced* alike, one will outlast or be easier to use than the other, and actually *cost* you less.

You'll find that we build into PYREX® labware useful features that make it cost you less than labware priced the same or even lower. For example: pipet tips have two bevels to eliminate rough edges which cause breakage; graduate tops have reinforcing beads to soak up impacts; a new dispenser pack for cover slips keeps them clean, ready for use.

Ask your laboratory supply representative to show you how to ferret out the actual *cost* of labware from the bewildering array of brands and *prices* you have to cope with.

CORNING
GLASS WORKS
3802 Crystal St. • Corning, N. Y.
CORNING MEANS RESEARCH IN GLASS

PYREX® Laboratory Ware . . . *the tested tool of modern research*

For additional information, use postcard facing back cover.

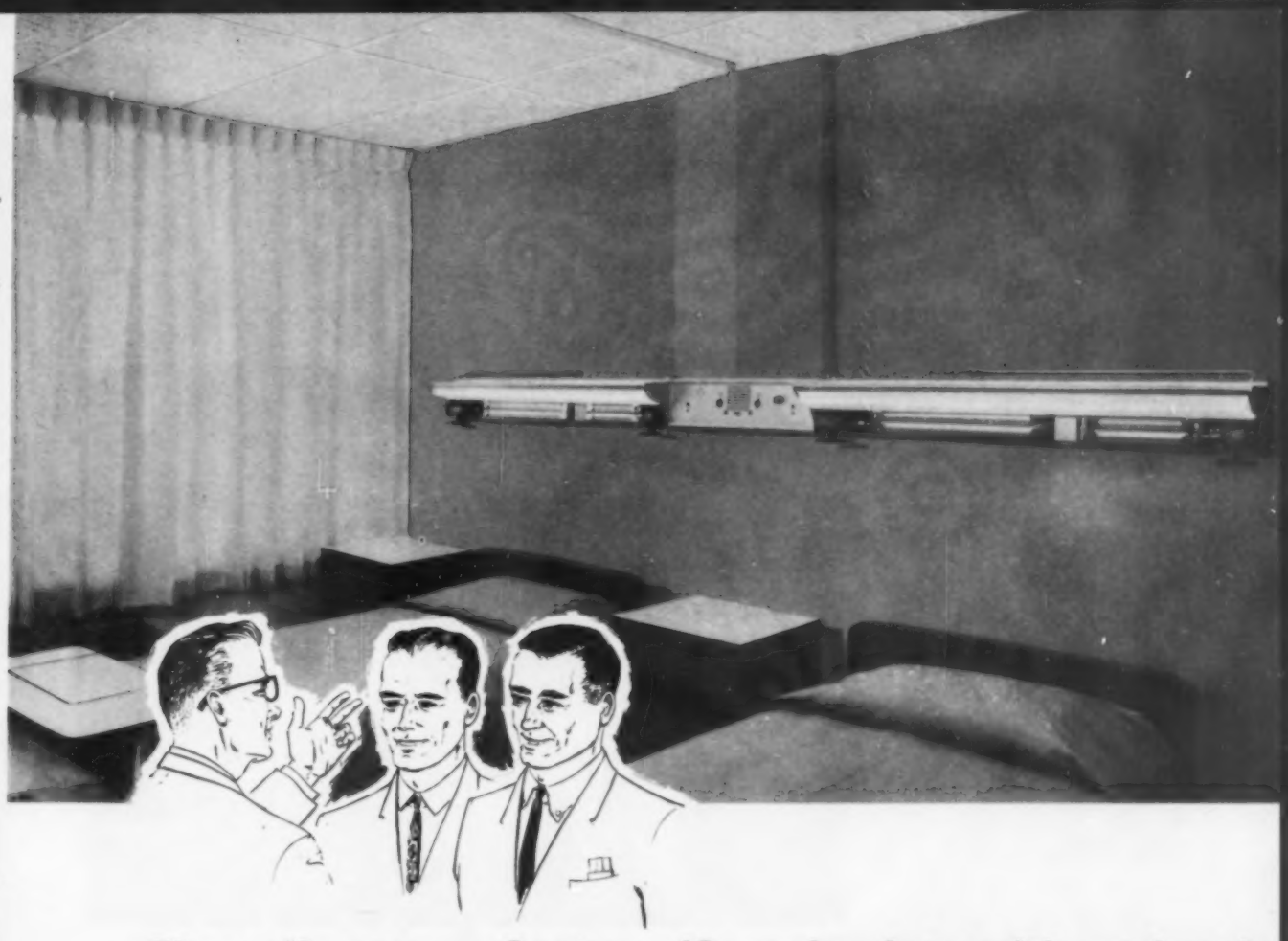
■ Better Film Contact ■ Non-Pitting ■ Longer Life ■ Easier Cleaning ■ Static Resistant

NEW ANSCO DURA-SPEED SCREENS! At last, you can work at either high or low KVP's with significant increases in speed! And new Ansco Dura-Speed Screens make this possible. Never before has a screen combined all the benefits of durability, static resistance, consistent quality, *plus* better screen-film contact for maximum image quality.

NEW ANSCO DURA-D SCREENS! Ansco's Dura-D Screens actually have solved the basic X-ray problem of combining speed *and* ultra-fine detail. And Ansco Dura-D Screens also give you all the benefits and outstanding characteristics inherent in all Ansco X-ray Products.

Improve quality, switch to Ansco Non-Pitting Intensifying Screens today. For further information, call or write: Ansco X-Ray Department, Ansco, Binghamton, New York, A Division of General Aniline & Film Corp. *Manufacturer of World Famous High-Speed X-ray Film.*

Ansco
X-ray



They all agree...Centron-10 modernizes with savings!

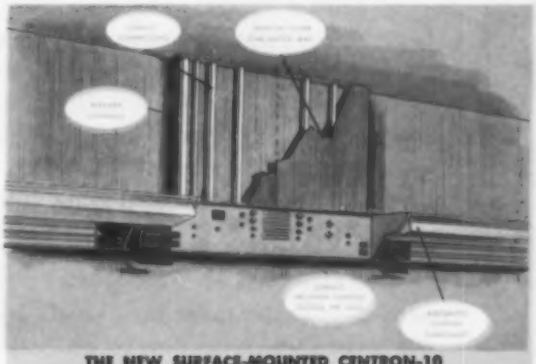
Many hospital administrators, consultants, architects and engineers across the country agree that the Centron-10 is a remarkable innovation in the economical integration and modernization of the hospital plant. There is no other system like it.

THE NEW SURFACE-MOUNTED CENTRON-10

The new surface-mounted Centron-10 is the modern way to update any hospital bedroom. The unique system provides totally integrated lighting for every seeing task—from glare-free general lighting to reading and examination lamps on extendable arms. It also consolidates the patient service equipment into a single, compact unit.

Remodeling with Centron-10 eliminates the clutter of individual services on the walls. It streamlines the appearance of the room and greatly reduces housekeeping problems.

It can be installed with minimum "down-time" and minimum disturbance to hospital activity. It also means minimum loss in room occupancy revenue.



THE NEW SURFACE-MOUNTED CENTRON-10

Centron-10 may be mounted directly to the surface of any type of wall construction. All service connections may be external to the wall concealed by a shallow snap-on cover.

Centron-10®

Recognizing its importance to the hospital remodeling program, Centron-10 includes provisions for maximum compatibility with existing nurse-call and oxygen-vacuum systems. Write for bulletin F02 describing specific installation variations.

SUNBEAM LIGHTING COMPANY

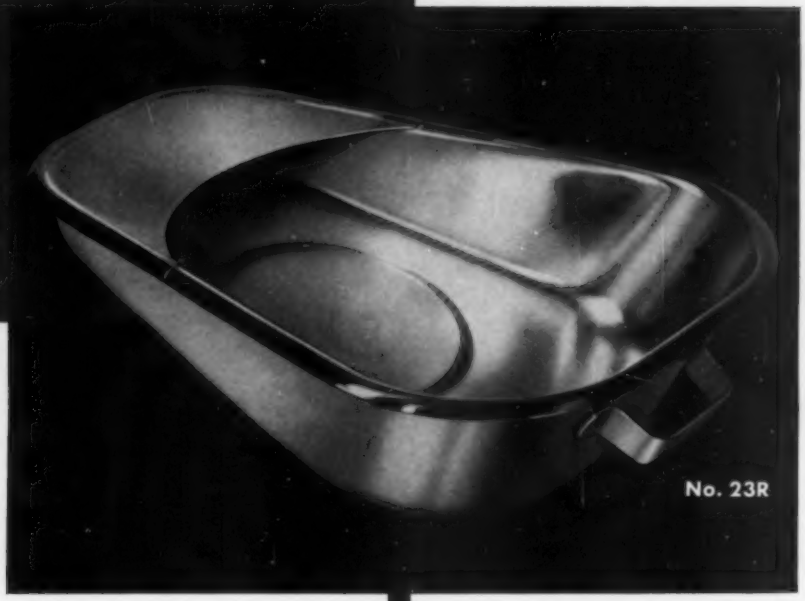
777 East 14th Place, Los Angeles 21, California — 3840 Georgia Street, Gary, Indiana

Greater Comfort,
Convenience, Safety

NEW POLAR WARE

stainless steel

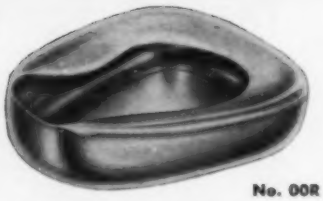
Fracture Bed Pans



No. 23R

From the patient's personal approach, or from your functional, practical point of view, the new Polar Ware fracture pan is preferred for bed service. Smaller in size and flatter in design than a pan of conventional design, it can be slipped into place far more easily . . . a convenience feature of special importance in caring for immobilized, arthritic, elderly or overweight patients. Special shaping aids substantially, too, in maintaining correct body alignment — provides maximum patient comfort and safety.

Constructed of heavy gauge stainless steel, Polar Fracture Bed Pans guarantee years of extra service . . . and because they're welded in one solid piece, they have a seamless, satin-smooth inside surface, completely free of crevices or any area that accepted aseptic methods will not make sterile. Leading supply houses from coast to coast carry Polar Ware Fracture Bed Pans — premium in everything but price. Ask the salesmen who call on you, or write



No. 00R

Also by Polar Ware — Panette No. 00R of heavy gauge stainless steel — scaled to children's size. Seamless construction.

No. 15R

Standard size Bed Pan No. 15R of Heavy Gauge Stainless Steel. Seamless construction.

Polar Ware Co.

4300 LAKE SHORE ROAD
SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54
Room 1455

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New York 17, N. Y.

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*Designates office and warehouse

BETTER BUILDINGS, higher maintenance standards and the persistent rise of labor costs are sparking the demand for mechanized floor care equipment. This swing to mechanization also can be attributed to the speed and consistency of results with powered equipment.

Clarke is making major strides in the development of complete mechanization of commercial, institutional and industrial building maintenance. Since 90 percent of the floor care dollar is spent on labor, these new developments in the design and manufacture of Clarke products are welcomed by building management and maintenance men everywhere. In fact, rapid progress in the mechanization of floor care is responsible for *Clarke being the best known name in floor machines.*

The Clarke line of job-designed equipment includes power floor scrubber-polishers ranging in diameter from 12 to 23 inches; heavy duty wet-dry vacuum cleaners with attachments for cleaning everything from floor to ceiling; rug, carpet and upholstery cleaning equipment; and the self-propelled Clarke-A-matic floor scrubber-vac in electric, gasoline, propane and battery powered models for large areas.

Thus, the right size and type equipment for any maintenance program is provided. And, when used in the proper manner, it guarantees the highest measure of building sanitation and cuts costs to dimes instead of dollars.

Years of accumulated "know-how" in the field of floor care is placed at the disposal of every Clarke user through qualified Clarke representatives and distrubutors.

And, the Clarke nationwide network of service branches is a guarantee that Clarke services what it sells.

So it is, that buyers concerned with the housekeeping problems of schools, hospitals, office buildings, industrial plants, warehouses, retail stores, churches and other buildings prefer and select Clarke mechanized equipment.

You, too, can enjoy substantial savings and highest sanitation standards by selecting the right Clarke mechanized floor care equipment. Write for details. Better yet, ask for a demonstration.

Clarke
FLOOR MACHINE COMPANY
DIVISION OF STUDEBAKER-PACKARD CORPORATION

522 E. Clay Avenue, Muskegon, Michigan

THE BEST KNOWN NAME IN FLOOR MACHINES

Authorized Sales Representatives and Service Branches in Principal Cities — Distributed in Canada: G.H. Wood & Co. Limited, Box 34, Toronto 18, Ont.

in the DESIGN of TUBES and CATHETERS

. . . . . Combines New Exclusive Design of Argyle Polyvinyl with Features You Have Liked in Rubber

• Tubing Connections No Longer a Problem

As every nurse and technician knows, practically all the inconvenience encountered in the use of medical and surgical tubing is involved in connecting tube-to-tube, tube-to-patient, or tube-to-machine or other apparatus.

Argyle exclusive, connector and funnel ends are integral parts of the tubing itself; helps the user two ways: 1) No time wasted searching for separate connectors; instant attachment, self-fitting, tight seal. 2) Integral connector of same transparent material as tube itself does not interrupt observation of flow.

• Satin Smooth Eyes—Properly Related to Lumen Size—Scientifically Beveled Tips

Exclusive, unique Argyle process assures well-rounded, softly beveled eyes—no sharp or ragged edges. Reduces chance of trauma. Compare by feel or micro-examination this important difference between Argyle and other tubes.

If eyes are too small, maximum flow is impossible. If eyes are too large relative to lumen size, kinking or bending may occur during insertion—and particles are admitted through the eye which may block the tube. All Argyle eyes are scientifically shaped and sized in relation to the lumen size.

All open-end tube tips are scientifically beveled to create soft smooth opening without sharp edges. Tips are free of ragged edges that can irritate patient or obstruct flow.

• Water-White Clarity—Perfect Transparency

Argyle tubing is as transparent as water along the entire length. No added connectors to distort or obscure the progress of flow. Only oxygen catheters, cannulae and tubes are tinged with transparent medium green.

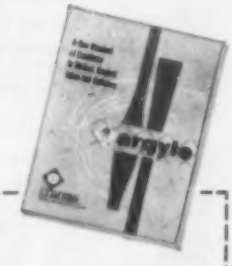
• Surgical Grade Polyvinyl Tubing—Quality Controlled by Rigid Inspection

Argyle is made of the highest grade polyvinyl tubing in an approved surgical grade formulation—odor-free, taste-free, non-toxic, completely inert in contact with body fluids.

Although designated expendable and priced for one-use disposability, Argyle quality control standards are maintained at a high level by rigid inspections at all stages of production. Argyle may be chemically cleaned or sterilized for re-use by boiling according to recommended procedures.

Complete Facts Available in Argyle Catalog

Send for complete Argyle Catalog containing detailed specifications and illustrations of each item in the Argyle line of Tubes and Catheters. Use coupon to request your copy or ask your Aloe Representative to show you actual samples.



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DIVISION OF BRUNSWICK CORPORATION

World's Foremost Hospital Supplier

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A. S. Aloe Company
Division of Brunswick Corporation
1831 Olive St., St. Louis 3, Mo.

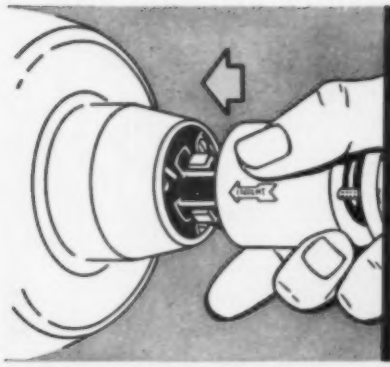
Please send New Argyle Tubing and Catheter Catalog.

Name.....

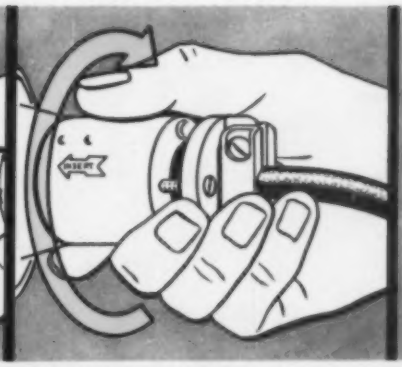
Hospital..... Street.....

City..... Zone..... State.....

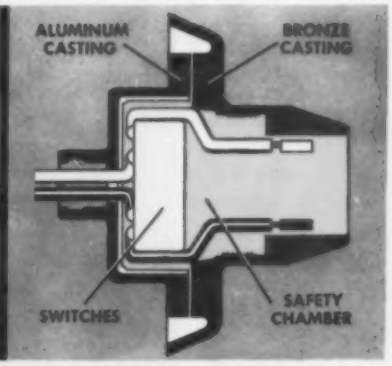
For additional information, use postcard facing back cover.



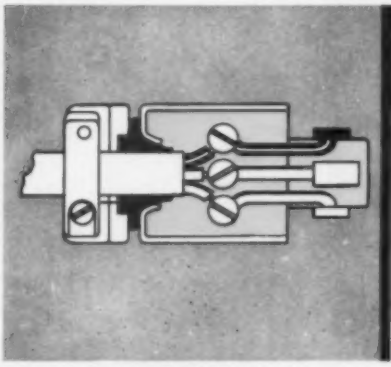
PLUG CANNOT PULL OUT ACCIDENTALLY
Direct pull on wire will not loosen plug to cause accidental arcing. Spring pressure and special keyed construction hold it firmly in place when current is flowing.



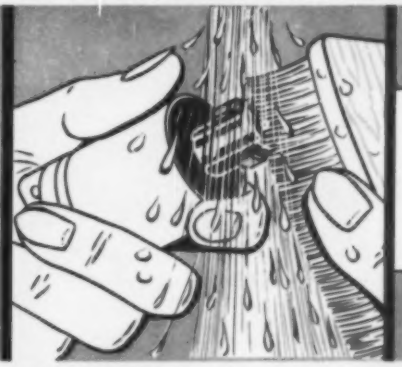
NO ARCING WHEN PLUGGING OR UNPLUGGING
Outlet is electrically "dead" until plug is completely inserted and rotated 22-25 degrees. Turning in reverse direction disconnects current before plug is removed.



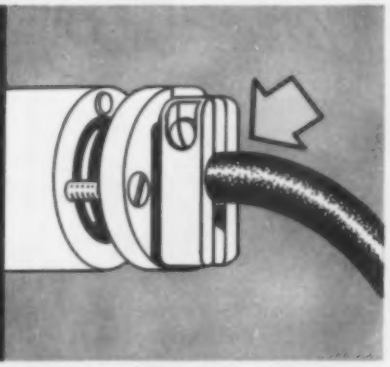
SWITCHING TAKES PLACE INSIDE VAPOR-TIGHT SAFETY CHAMBER
Plastic-enclosed switches are inside a safety chamber formed by heavy bronze and aluminum castings. These prevent spread of explosion if gas seeps in.



NO AIR SPACES INSIDE PLUG TO COLLECT GAS OR MOISTURE
After plug is wired, electrician pours a self-hardening insulating resin into all air spaces. Interior of plug becomes solid, watertight, vapor-tight mass.



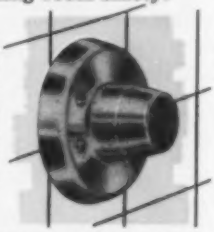
PLUG CAN BE WASHED WITHOUT DISMANTLING AND REWIRING
Operating room spillage quickly and easily removed by washing. When moisture is wiped off, plug can be used immediately. Water cannot penetrate to wiring.



CORD CANNOT PULL OUT
Special double-clamping cord grip relieves strain on wire connections inside plug. Further protection is provided against arcing caused by loose connections because wires and terminals are embedded in plastic.

EXPLOSION-PROOF
ELECTRICAL OUTLET WITH WASHABLE PLUG
FOR OPERATING ROOM SAFETY

Here is a truly explosion-proof outlet and plug. It was designed at the request of an outstanding New England hospital—and with the cooperation of a noted authority on operating room safety.



It is the "Hubbellock" Explosion-Proof Outlet and Plug. As shown above, it incorporates numerous safeguards against arcing and makes it virtually impossible for explosive or flammable gases to accumulate within the unit.

Listed by Underwriters' Laboratories, Inc. for use in hazardous locations (Class I. Groups C and D), and described by the National Fire Protection Association, it requires no special wiring and can be installed by any licensed electrician.

Any of your 125-volt A.C. surgical appliances of the explosion-proof type may be operated from the "Hubbellock" Explosion-Proof outlet simply by substituting the specially keyed "Hubbellock" Explosion-Proof plugs for present plugs. This is necessary because no other type of plug will operate this explosion-proof outlet. However, appliances equipped with this plug will operate in any standard 3-wire "Hubbellock" outlet.

20 amperes, 125 volts, A.C.

Write for complete information.

EXPLOSION-PROOF

Hubbellock®

REGISTERED TRADEMARK OF HARVEY HUBBELL, INCORPORATED

WIRING DEVICES

HARVEY HUBBELL, INCORPORATED
BRIDGEPORT 2, CONNECTICUT
IN CANADA: SCARBOROUGH, ONTARIO

SANITATION is all-important here, and with Jamison Stainless Steel Clad Doors, cleaning is simplified, maintenance is no problem. Note Jamison Door Closer that saves refrigeration.

FOUR-WINDOW refrigerator front—also stainless steel clad—glazed with three thicknesses of plate glass ¼" thick. Sturdy hardware is chromium plated heavy cast bronze.

*The Bishop Clarkson Memorial Hospital was the winner of the 1955 "Hospital of the Year" award.

Gleaming JAMISON stainless steel clad doors selected for "Hospital of the Year"*

Like the new Bishop Clarkson Memorial Hospital in Omaha, Nebraska, more and more hospitals (and hotels and restaurants) are specifying stainless clad Jamison Doors to meet their rigid sanitary requirements at economical cost. Jamison's unmatched experience plus complete flexibility of design is your assurance of the practical solution to any door problem.

"How to Select and Specify Cold Storage Doors"—a helpful booklet you should have—answers your questions on the many factors involved in specifying cold storage doors. For your copy write to Jamison Cold Storage Door Co., Hagerstown, Md.

Architects & Engineers:
Leo A. Daly Co.
Omaha, Nebr.

Contractor:
Peter Kiewit & Sons Co.
Omaha, Nebr.

Insulator:
Kelley Asbestos Prods. Co., Omaha, Nebr.

JAMISON
COLD STORAGE DOORS
Jamison Cold Storage Door Co., Hagerstown, Md.

NURSES CALL SYSTEMS

Modular Design: Easy To Maintain

Combination phone and annunciator nurses station has satin finish stainless steel faceplate . . . rugged molded plastic construction . . . simple lift-off-the-phone answering . . . push button selection . . . override operation for emergency calls . . . flush, surface or desk mounting . . . these are some of the advanced features typical of the modern Nurses Call Systems offered by Couch . . . available in modular units so you can tailor a system to fit your individual requirements.

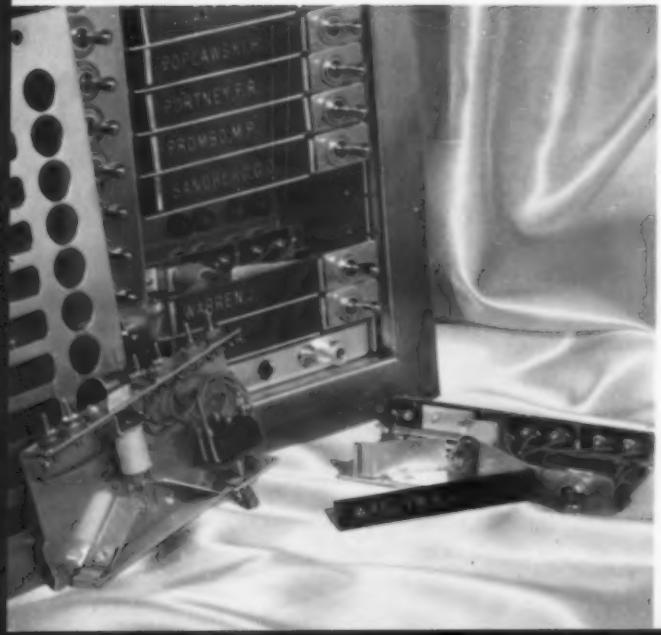
Nurses Station

LOCAL FIRE ALARM SYSTEMS

Modular Design: Great Flexibility

Fire alarm control panels are completely dead front . . . no possibility of electrical shock . . . plug-in relays completely enclosed . . . exceptionally compact cabinets . . . these are typical of the few standardized components . . . building block fashion to create a great variety of fire alarm systems . . . with approval of not only UL but the more restrictive federal, state and local codes . . . with provision for automatic fire detection and connection to city fire alarm system.

Fire Alarm
Control Panel



STAFF IN-OUT REGISTER SYSTEMS

Plug-in Units Give You A Wide Choice

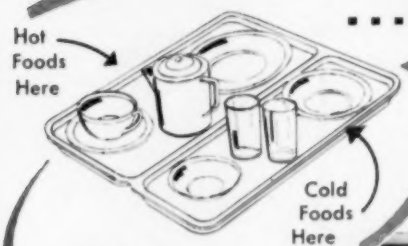
Each nametile holder is a plug-in unit complete with nametile, lamp, socket, reflector and switch or switches as required . . . makes it possible to assemble a unit tailored to your requirements . . . in half the space usually required . . . with a choice of signaling procedures . . . such as flashing lamps for message recall . . . choice of supplementary telephone equipment for voice communication.

Staff In and
Out Register

for complete details, write S. H. Couch Company, Inc. 3 ARLINGTON STREET NORTH QUINCY 71, MASS.

New Ideal UNITRAY

Hot foods Hot . . Cold foods Cold
. . . ALL ON THE SAME TRAY



The Unitray Concept — the newest, most modern method for centralized food service in hospitals was developed in conjunction with Mr. Henry Rothman, F.F.E.S., one of the nation's leading food service consultants.

Now, for the first time, you can have *all* of the advantages offered by "All on the same tray" service. No longer do you have to worry about the proper combining of hot foods onto the cold tray at a point distant from the kitchen.

IDEAL'S "All on the same tray" Unitray cart makes complete kitchen control of the centralized food service system possible.

A unique new method permits one side of the tray to be exposed to refrigeration while the other-side of the tray is exposed to heat. Thus, hot foods stay hot and cold foods stay cold — all the time.

Now, the tray can be completely assembled in the main kitchen. The complete tray set up is checked by the Dietitian just before the tray is put into its proper place in the cart. No reshuffling of tray items before delivery to patient. One set up — one check, and the tray is ready for delivery to the patient. Excellent holdover qualities built into the cart make it possible to maintain both hot and cold temperatures, even over long periods of time. Twenty trays in less space than ever before! The new Unitray carries 20 trays with plenty of room for a 10 ounce glass to stand upright on the tray. Yet, the overall length of the cart is only $53\frac{3}{4}$" almost $\frac{1}{3}$ less than old fashioned carts.

Write today for live demonstration of Unitray in your hospital

SWARTZBAUGH MANUFACTURING CO., Murfreesboro, Tenn.

INSTITUTIONAL EQUIPMENT • for modern institutions everywhere

Hollister *Ident-A-Band*®

In the hospital hushed for night, nurses have a special job to do — see that patients get both their needed night care and their valuable sleep. In hospitals using Ident-A-Band by Hollister, there's no need to wake a patient to check identity, or risk a sleep-confused "yes" in answer to any name. Just a glance at the wrist and you're sure of correct identity before giving medications or care. Ident-A-Band helps keep disturbances (and tempers) down . . . your error-free record up.

Whether by day or at night, you can depend on Ident-A-Band to identify the right patient. And your patients will like its comfort. Only Ident-A-Band offers skin-soft identification that cannot be altered, water-blurred or transferred to another person. It's no wonder that more hospitals in the United States and Canada prefer Ident-A-Band . . . for nine years the leader in on-patient identification. Write for samples and complete information about Ident-A-Band.

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SHOW THE PROUD PARENTS YOU SHARE THEIR PRIDE . . .

GIVE

Hollister® Inscribed® BIRTH CERTIFICATES

In public relations, as in friendship, it's often the "little things" that count most. A birth certificate may seem to be small amid the complicated details of running a hospital. But anything connected with the birth of a baby is magnified in the eyes of the parents. That's why Hollister Inscribed Birth Certificates are such effective builders of goodwill.

In every way a Hollister Certificate shows that you care . . . that you too are proud of the important event. Styled by leading designers and LithoGraved® on finest diploma parchment paper that will never fade, Hollister Inscribed Certificates are appreciated for their Heirloom quality. The cost is small, but the goodwill earned is priceless. Send for your new portfolio—including actual samples—of Hollister Inscribed Birth Certificates.

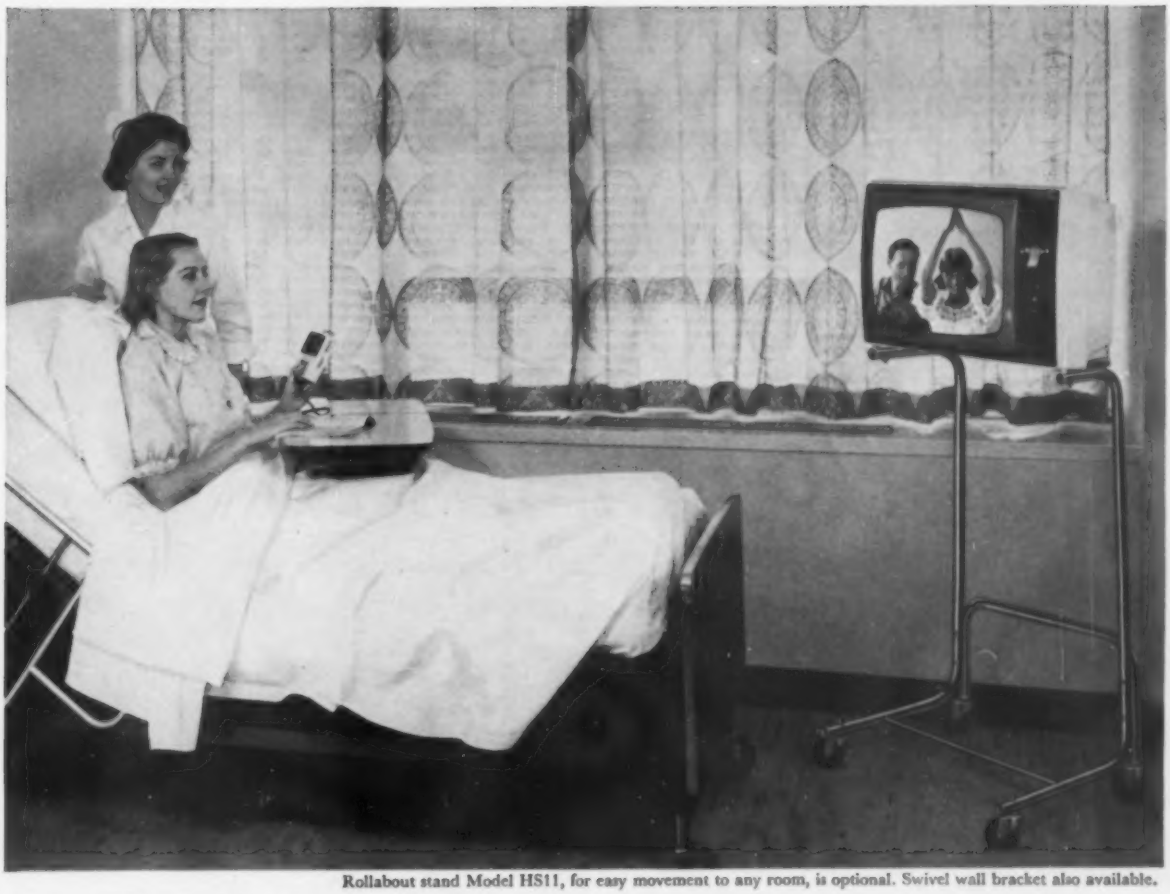

COMMUNITY HOSPITAL
JAMESTOWN, INDIANA

Certificate of Birth

This Certifies that
was born to
in this Hospital at o'clock, .m. on
the day of 20
In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officer, and its Official Seal to be hereunto affixed.

Hollister®
INCORPORATED

833 N. Orleans St., Chicago 10
In Canada, Hollister Limited
160 Bay St., Toronto 1



Rollabout stand Model HS11, for easy movement to any room, is optional. Swivel wall bracket also available.

RCA VICTOR Television with wired remote control makes hospital life easier for patients...and staff, too

The CONSORT—172 sq. in. viewable picture, Full-Picture 19-inch tube (overall diagonal). Optional swivel wall bracket saves floor space. Liquid resistant, non-breakable "IMPAC"® case. Heavy-duty power cord.

Specifications subject to change without notice.

RCA Victor television, with wired remote-control unit specially made for hospitals, permits patients to turn the set *on* or *off*, change channels and regulate picture and volume—without leaving the bed!

No staff attention or help is needed!

In addition, patients can listen, alone, to the personal speaker in the remote control unit *without disturbing others in the same room.*

This remote-control unit is but one of many extra-value features from RCA Victor. *New Full-Picture Model has* exclusive RCA Victor "New Vista" Tuner, with up to 45% more picture-pulling power to bring in clearer pictures from hard-to-get stations. And the 19″ Full-Picture screen is a bigger picture, with 172 sq. in. of viewable area, big enough even for a ward. For the most viewing pleasure for patients and the least staff supervision, look into this outstanding product of RCA quality and dependability.

Free booklet gives full information on models and on RCA's exclusive Hospital TV Lease Plan. Send for it.

RCA Sales Corporation, Box 1226-A40, Philadelphia 5, Pa.
Please send full data on RCA Victor Hospital TV

Name_____

Hospital_____

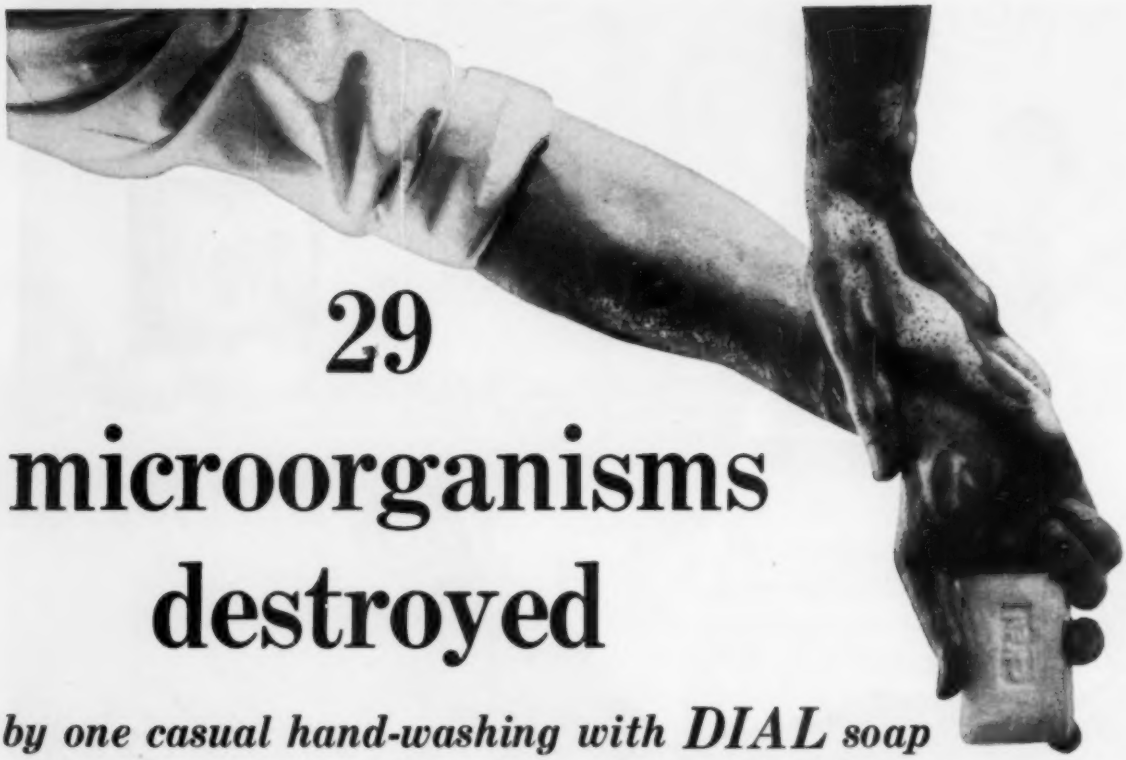
Street_____

City_____ Zone____ State_____

RCA The Most Trusted Name in Television

RADIO CORPORATION OF AMERICA TMK(s)®

For additional information, use postcard facing back cover.



29 microorganisms destroyed

by one casual hand-washing with DIAL soap

Routine use of Dial by patients and personnel suggested as an aid in eliminating one source of infection

New and more extensive tests have established that Dial soap destroys a wider range of gram-positive and gram-negative microorganisms, and controls their growth, than any other bar soap designed for hospital use. Latest tests show that Dial is effective against 29 strains with a casual hand-washing. These organisms include *six strains of Staph aureus*, along with others which resist antibiotics.

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide has long been known for its effectiveness against skin bacteria that cause perspiration odor. Dial's antibacterial properties have been familiar to physicians for a considerable time. And now, this new evidence sharply points up the benefits of Dial for routine use by hospitalized patients and hospital personnel.

With its unique antibacterial benefit you might expect to pay extra for Dial—but you don't. You can trim costs even more by choosing the bar sizes suited to your hospital needs. Three hospital-tested sizes are available—1, 1¼ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

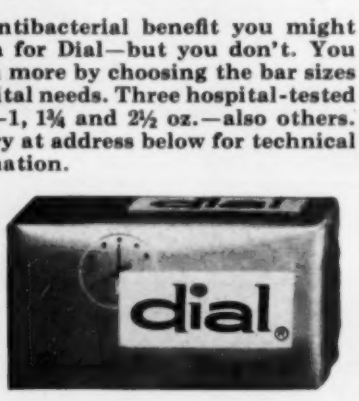
Antibacterial spectrum of Dial soap

Microorganism	Soap Concentration For Total Kill, ppm* Dial
1. S. aureus (No. 209) **	10
2. S. aureus 388010 ***	10
3. S. aureus 388014 ***	25
4. S. aureus 388062 ***	25
5. S. aureus 388115 ***	10
6. S. aureus 388128 ***	10
7. S. lutea	3
8. E. coli	5000
9. S. oranienburg	4000
10. S. typhosa	9000
11. S. pullorum	4000
12. P. mirabilis	6000
13. P. vulgaris	8000
14. S. marcescens	4000
15. S. flexneri	5000
16. P. fluorescens	9000
17. B. cereus	10
18. B. megaterium	10
19. B. s. v. niger	25
20. B. s. v. atterimus	10
21. B. ammoniagenes	10
22. S. faecalis	25
23. M. phlei	10
24. M. smegmatis	10
25. N. catarrhalis	10
26. C. albicans	4000
27. S. cerevisiae	4000
28. T. interdigitale	50
29. Airborne mold	1000

*Soap concentration: Casual handwashing: 80,000 ppm (average) deliberate scrub: 120,000

**F. D. A. Strain (biological standard).

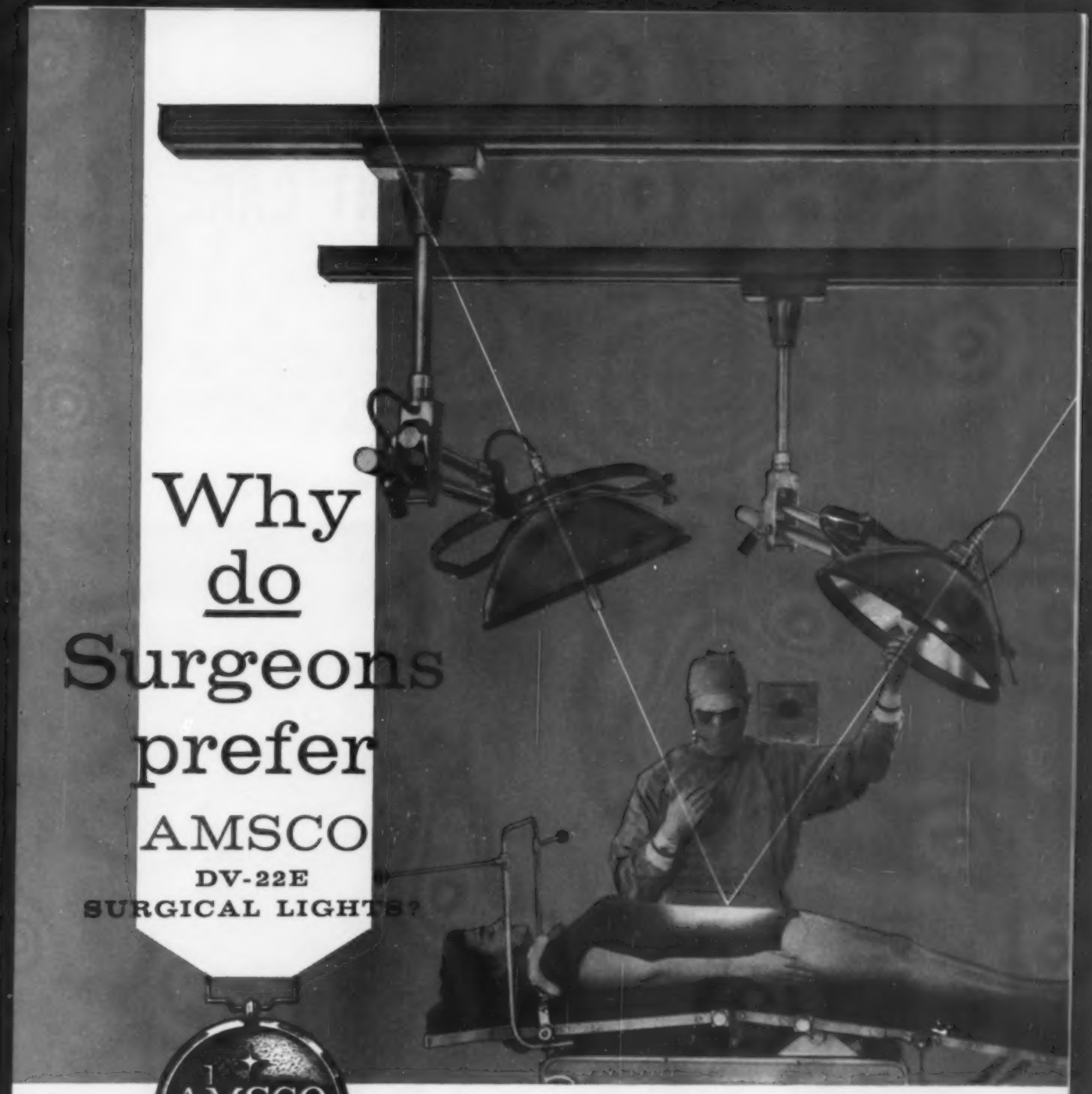
***Antibiotic-resistant strains supplied thru the courtesy of Mt. Sinai Hospital, New York, New York.



from the Industrial Soap Division of

ARMOUR AND COMPANY

1355 W. 31st Street, Chicago 9, Illinois



Why do Surgeons prefer AMSCO DV-22E SURGICAL LIGHTS?

The twin reflectors provide cool, shadow-reduced "surgical light" for *every* procedure.

Of course the ultimate reason is for better visibility . . . under cooler operative conditions. However, another factor affects the surgeon's preference . . . *his confidence in the integrity of Amsco lighting research.* For years, knowledgeable surgeons the world over have looked to Amsco's proved "dual video" principles for more effective surgical illumination.

DV-22E accepts this challenge of continued trust. It is a surgical light of *abundant color-corrected, cool illumination.* Two highly efficient polished reflectors permit excellent shadow reduction. Each may be guided easily, smoothly by the surgeon or his nurse along strong, 9-foot extruded aluminum tracks. Whatever the procedure, DV-22E will fulfill every operative lighting need.

For your copy of "LIGHTING FOR THE HOSPITAL," *write for LC-122.*

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

The most trusted name in Surgical Lighting

IMPROVED EFFICIENCY AND PATIENT CARE

Hospitals seek improved efficiency, better patient care, decreased operating expenses, and increased net revenue. These goals can and have been achieved in a major aspect of hospital operations—use of injectables—through the TUBEX closed injection system.

The TUBEX system consists of a durable, breech-loading syringe and presharpened, presterilized needle and glass cartridge units containing premeasured doses of medication. After loading the syringe, and injecting, the cartridge-needle unit is discarded. As much as 70% of commonly used injectables are available in TUBEX form. Additional flexibility is provided by empty sterile cartridge needle units.

The TUBEX system provides benefits for business office, nurses, pharmacists, and physicians.

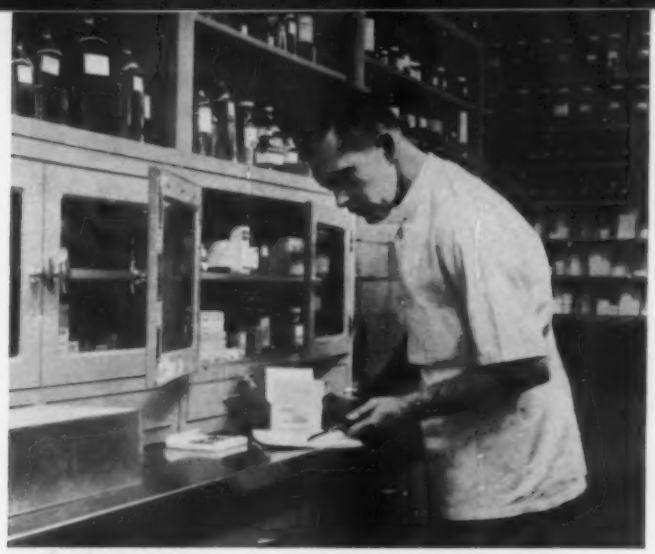
TUBEX®

Closed Injection System, Wyeth

TUBEX®, *Hypodermic Syringe, Wyeth*
TUBEX®, *Sterile Cartridge-Needle Unit, Wyeth*

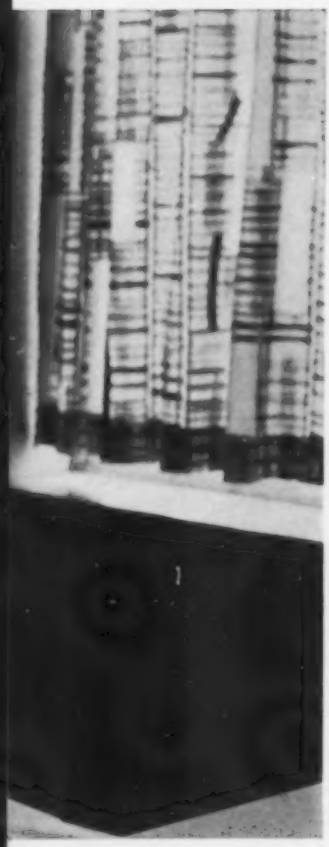
Wyeth Laboratories Philadelphia 1, Pa.

ADMINISTRATORS LIKE TUBEX. The TUBEX system means more accurate accounting and billing. Only one purchase entry required as there are no multidoses to divide. A single purchase order for cartridges simplifies buying. Inventory control is easier; medication is ordered, dispensed and accounted for in multiples of single doses. Because exact amount of medication is always known, billing to patients is more accurate.

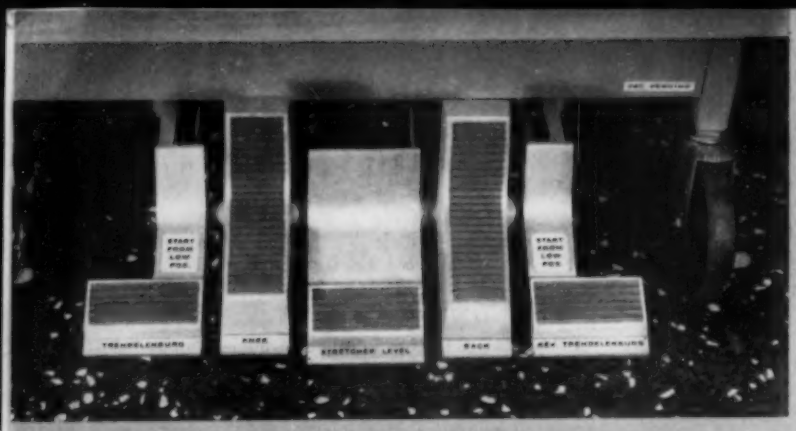


PHARMACISTS LIKE TUBEX. Easier, more convenient storage of TUBEX units recommends this system over the usual ampuls and multidose vials. Clear labeling and accurate inventorying of single-dose units result in more efficient filling of prescriptions and less chance for error; tamper-proof cartridges discourage narcotics pilferage.

NURSES LIKE TUBEX. No time is lost in assembling syringes, sponging vials, measuring doses, rinsing syringes and needles. No clean-up problem: cartridge and needle are discarded after injection. The familiar frustrations, syringe breakage and plugged needles, are almost impossible with TUBEX. An added benefit: no multidoses to divide, no drugs spilled and no contact sensitization. Patients appreciate the relatively painless sharp, new needles.



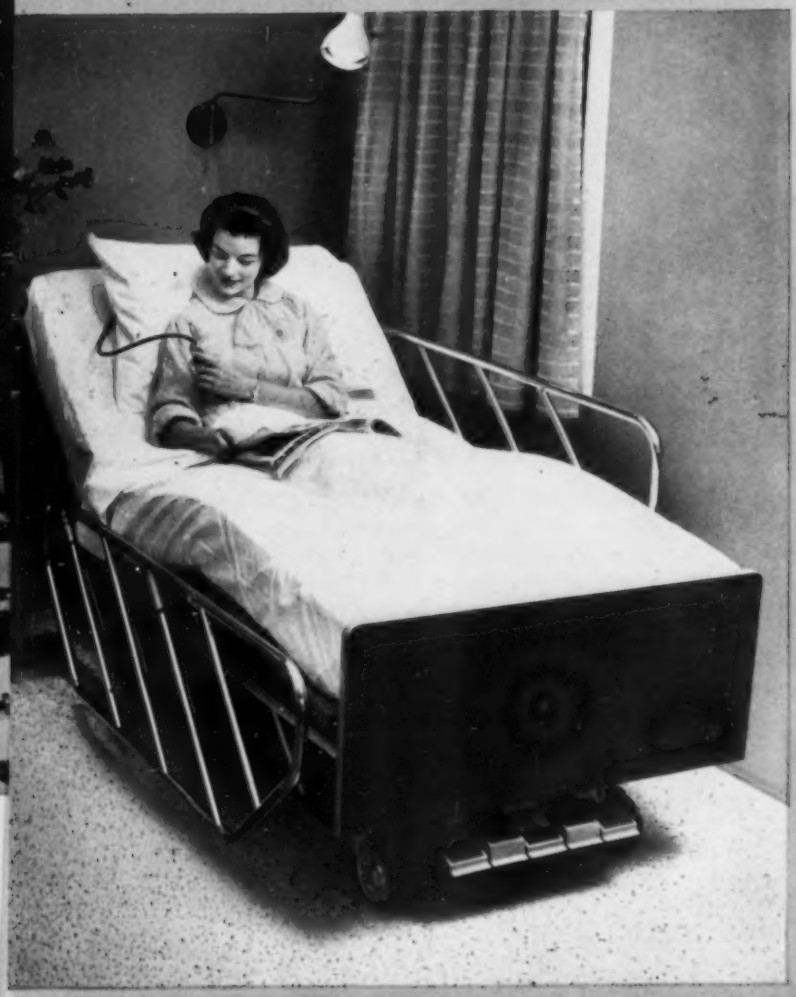
M.D.'s LIKE TUBEX. Accurate dosage and asepsis are major benefits. Each presterilized needle-unit contains premeasured amount of medication. The TUBEX sterile cartridge-needle unit is used but once and cannot transmit cross infections (serum hepatitis).



TOUCH-TOE Control

sets new standards of simplicity and convenience in the

All New Borg-Warner Hospital Bed



With handy control switch, patient can adjust movement of bed to positions pre-set by nurse with TOUCH-TOE selector—thus freeing staff for other duties. Master switch permits hospital personnel to immobilize entire unit. Bed is listed by Underwriters' Laboratories, Inc., for use with oxygen administering equipment.

Fully motorized – yet priced so low any hospital can afford it

Now—Borg-Warner brings you a fully motorized hospital bed without equal in simplicity, convenience and low cost.

With exclusive TOUCH-TOE position selector, there's no bending, stooping or reaching—just a touch of the toe selects the desired position, and patient control switch adjusts the bed, automatically, smoothly and quickly. It's as easy as that.

Equally important, the Borg-Warner bed is a marvel of simplicity. The single, low-amperage motor operates the bed through all positions: Trendelenburg, Reverse Trendelenburg, Stretcher Level, Knee and Back Rest, Fowler, High-Low, and Vascular.

In low position, the Borg-Warner bed is only 16 inches from the floor—at stretcher level a full 34 inches, 4 to 8 inches higher than any other motorized bed.

Designed in consultation with recognized hospital authorities, and thoroughly tested in leading hospitals, the Borg-Warner bed now puts the advantages of a simplified, dependable, fully motorized bed within reach of any hospital.

INGERSOLL B-W PRODUCTS

BORG-WARNER

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DIVISION OF BORG-WARNER CORP.

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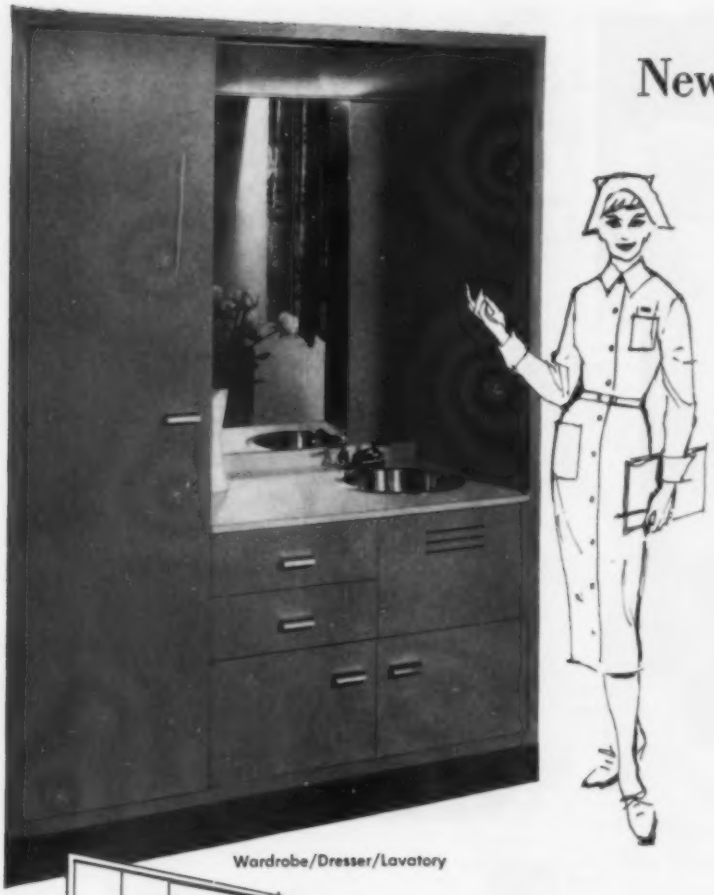
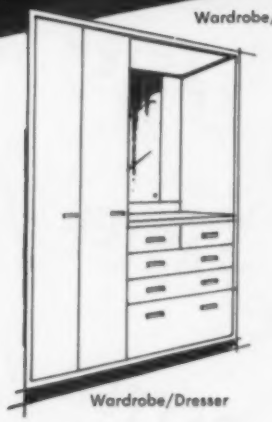
New developments in patient care...

by St. Charles



Wardrobe/Dresser/Lavatory

Medi-Serv Unit



Wardrobe/Dresser

Wardrobe/Lavatory

Nurses Station

"Patient Line" Wardrobes. Functionally designed to meet all storage, vanity and lavatory requirements. An attractive, efficient and economical solution to patient room storage and grooming convenience. Completely flexible . . . built-in or free-standing . . . meets varying patient room needs in new plans or alterations of existing buildings.

Nurses Station. Compact, space-saving "Medi-Serv" Unit includes sink, refrigerator and adequate storage for medicine preparation needs. Custom designed nurses desk includes nurses call unit.

For complete information *and specifications of the complete line of St. Charles casework systems for all hospital storage requirements write, on your letterhead, to:*

St. Charles

Hospital Casework Systems

St. Charles Mfg. Co., Dept. MHH-2, St. Charles, Ill.

For additional information, use postcard facing back cover.

now available in new multi-dose vial

Terramycin•

BRAND OF OXYTETRACYCLINE

INTRAMUSCULAR SOLUTION

conveniently preconstituted for prompt parenteral administration in office or at bedside

new 10 cc. vial permits greater economy, convenience, and flexibility in dosage

IN BRIEF

Terramycin Intramuscular Solution, a *preconstituted* parenteral form of oxytetracycline with 2% Xylocaine* as a local anesthetic, facilitates prompt initiation of broad-spectrum antibiotic therapy when immediate oral administration is inconvenient or impractical. There is a low incidence of irritation or pain at the injection site. Availability of the *new,* multi-dose 10 cc. vial permits greater *economy, convenience,* and *flexibility* in dosage. The dependability of Terramycin is based on broad antimicrobial effectiveness, excellent toleration, and low order of toxicity.

INDICATIONS: All oxytetracycline indications whenever initial or continuing therapy with I.M. injection is indicated. Compatible oral therapy may then be given with Cosa-Terramycin® Capsules or Cosa-Terrabon® Suspension. Effective against both gram-positive and gram-negative bacteria, rickettsiae, spirochetes, and large viruses, Terramycin therapy is indicated in a great variety of infections due to susceptible organisms. These include infections of the respiratory tract, ophthalmic and otic infections, gastrointestinal infections, genitourinary infections, soft-tissue infections, and many others.

ADMINISTRATION AND DOSAGE: For intramuscular injection only. Unless otherwise specified, a dose of 100 mg. every 8-12 hours, or a single daily dose of 250 mg. should be adequate for most mild or moderately severe infections. In *severe* infections, 100 mg. every 6-8 hours or 250 mg. every 12 hours may be necessary. Dosage for infants and children is proportionately less and should be determined in accordance with age and weight of the patient, and severity of infection.

SIDE EFFECTS AND PRECAUTIONS: Aside from occasional mild pain at injection site, adverse reactions (including allergic) have been rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. After insertion of needle, aspiration should be attempted before injecting to avoid inadvertent administration into a blood vessel; care should always be taken to avoid injecting into a major nerve or its surrounding sheath. Subcutaneous and fat-layer injection may cause mild pain and induration, which may be relieved by an ice pack.

Use of antibiotics may result in an overgrowth of nonsusceptible organisms—particularly monilia and resistant staphylococci. If a new infection caused by a resistant pathogen appears, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing.

SUPPLIED: *Terramycin Intramuscular Solution* is available in the new 10 cc. multi-dose vial, providing five 2 cc. doses, 50 mg./cc., and in 2 cc. prescored glass ampules, containing 100 mg. and 250 mg., packages of 5 and 100. For maximum rapidity of effect—*Terramycin Intravenous,* in vials of 250 mg. and 500 mg. (buffered with 1 Gm. and 2 Gm. ascorbic acid, respectively). Available for oral therapy: *Cosa-Terramycin® Capsules,* 250 mg. and 125 mg.; *Cosa-Terrabon® Oral Suspension* (preconstituted), 125 mg. per 5 cc. teaspoonful, in bottles of 2 oz. (60 cc.) and 1 pint; *Cosa-Terrabon® Pediatric Drops* (preconstituted), 5 mg. per drop (100 mg. per cc.), bottle of 10 cc. with calibrated plastic dropper. In addition, a variety of other systemic and local dosage forms are available to meet specific therapeutic requirements.

More detailed professional information available on request.

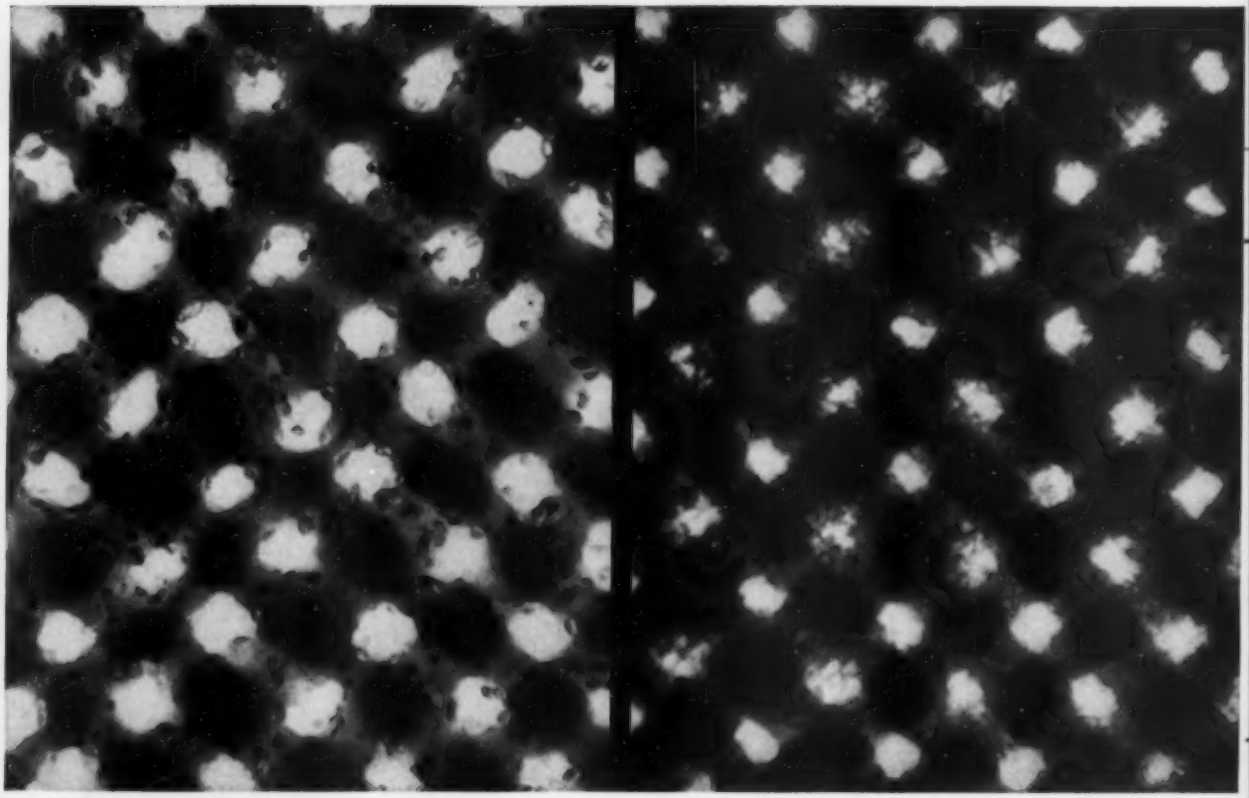
*Xylocaine® is the trademark of Astra Pharmaceutical Products, Inc. for its brand of lidocaine.

a reservoir of dependable performance— Terramycin® therapy

Science for the world's well-being™ Pfizer PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York*

Now with Velva-Soft-G

hospital linens can fight infections



These companion photomicrographs show Velva-Soft-G's effective antibacterial control on a laundered sheet placed in a suitable medium seeded with Staphylococci. At left is the untreated sheet with dark "staph" colonies growing profusely. At right is the sheet treated with Velva-Soft-G. This picture clearly shows that Velva-Soft-G inhibited bacterial growth.

What Velva-Soft-G is:

It is a special cationic fabric softener with specific antibacterial chemicals to control a wide spectrum of germs, including the antibiotic-resistant strains of Staphylococcus aureus. Because of its cationic charge, Velva-Soft-G readily attaches itself to fabric when it's applied in the last cycle of the laundering operation.

Why it was developed:

Resistant strains of Staphylococcus aureus are held responsible for patient infection in many hospitals. Velva-Soft-G was developed to help hospitals' over-all environmental sepsis program—by controlling the spread of organisms on lint. The final formula evolved from variations tested on approximately three million pounds of hospital-washed linens.

How it controls germs:

Effective with the first application, Velva-Soft-G does two important things. (Regular laundering techniques do not do them.)

1. It gives fabric an antibacterial shield which remains effective even in prolonged storage. Velva-Soft-G effectively inhibits bacterial growth all the time linens are used. It continues to be effective in the crucial time when linens are being returned for re-washing and re-treatment.

2. It substantially reduces the incidence of air-borne infection through lint control. Bacteria literally ride on the lint particles from patient to patient. Lint is caused by fiber breakage. Velva-Soft-G's lubricity reduces fiber breakage and subsequent lint formation.

Velva-Soft-G does even more:

It softens all fabrics to increase patient comfort. It eliminates ammonia formation and odor in urine-soiled linens. Velva-Soft-G controls many strains of mildew-causing fungi which can be a problem when soiled, damp linens are stored prior to washing.

It is not toxic to patients:

Hospitals have evaluated Velva-Soft-G on linens used for many months without finding a single case of dermal sensitization due to Velva-Soft-G.

It is economical:

The cost is less than 3¢ per patient, per day. This should be considered in view of the objective of controlling infection on all hospital-treated linens. Velva-Soft-G can provide certain operating economies, too. It makes the laundry load easier to handle; reduces extraction and drying time; and eliminates static electricity for faster feed through the flatwork ironer. In addition, all treated fabrics will have a longer wear life because Velva-Soft-G's fiber lubricity reduces breakage.

Organism Counts on Treated and Untreated Linens*

*Upper figure represents beginning of operation, lower figure the end.

Treatment	Suds 1st	Suds 2nd	1st	2nd	3rd	4th	Sour Bath	Over-all Avg.
Total Organisms per Ml.*								
1. *Water Only* (no load)	1 1	1 1	0 0	1 2	4 4	1 2		1.5
2. *Regular Load* (bed jackets) Never treated with germicide	130 130	20 22	180 170	130 110	225 110	165 290	320 200	135.8
3. *Regular Load* (bed jackets) Treated with Velva-Soft-G before patient use	1 0	0 0	1 1	2 1	3 2	1 0	0 0	0.9

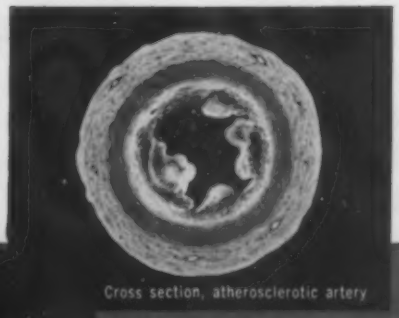
The over-all average indicates that Velva-Soft-G apparently reduced the high growth of organisms to the virtually germ-free level of the tap water.

For technical information on clinically-proven antibacterial treatment for hospital linens with Velva-Soft-G, please write: B. J. August, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.

ARMOUR AND COMPANY

Industrial Soap Division
1355 West 31st Street
Chicago 9, Illinois

outstanding nutritional research achievement



Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol

MAZOLA®

MARGARINE
scientifically formulated with pure liquid **non-hydrogenated** MAZOLA Corn Oil.

U.S. Pat. No. 2,935,039

MAZOLA Margarine is an economical tablespread and serves as a solid shortening, rich in linoleates and low in saturates—making it an ideal dietary adjunct in the management of serum cholesterol. It contains 2 to 3 times as much natural linoleic acid as any other margarine readily available in grocery stores from coast to coast, and 5 to 8 times as much as butter. It contains no dairy or animal fats, no coconut oil, and no cholesterol.

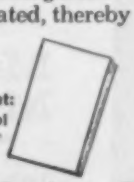
MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine—liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.

The average daily intake, two ounces or 56.8 Gm. (4 tablespoons) of MAZOLA Margarine, supplies

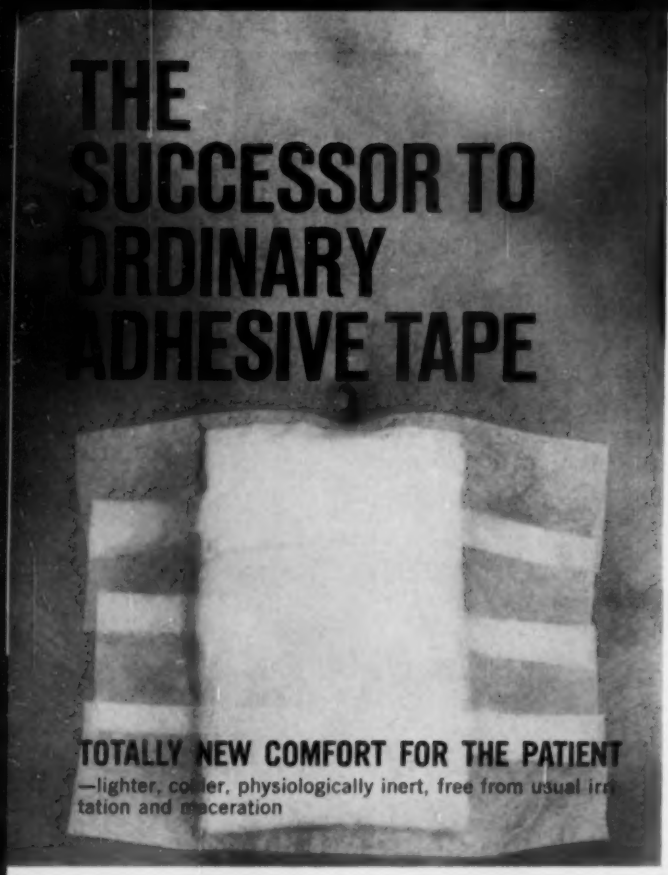
Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
Plant sterols (sitosterols)	215 mg.
Natural tocopherols	30 mg.
Vitamin A	1870 USP units
Vitamin D	250 USP units
Calories	415

Available in the refrigerator sections of grocery stores in the same general price range as other premium quality margarines, in 1-lb. packages (four ¼ lb. sticks).

Send for free booklet:
"Recent Advances in the Dietary Control of Hypercholesterolemia."



BEST FOODS • Division of Corn Products Co., NEW YORK 22, N. Y.

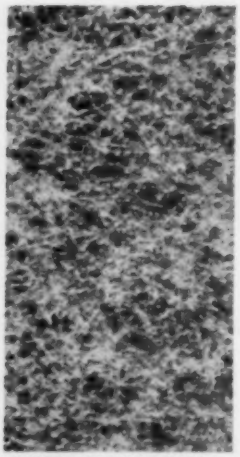


Reg. U.S. Pat. Off.

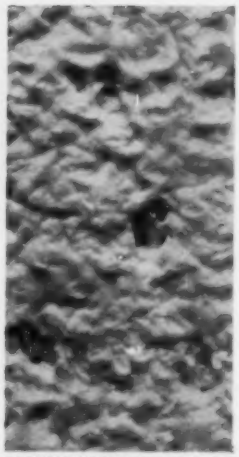
Scotch BRAND

SURGICAL TAPE MICROPOROUS

No. 530



"SCOTCH" SURGICAL TAPE



ORDINARY PERFORATED TAPE

EXCLUSIVE CONSTRUCTION **LEFT:** Macrophotograph (20x) of "SCOTCH" Brand Surgical Tape shows totally microporous structure of both the nonwoven backing and the thin, non-reactive, non-mobile adhesive which permit unprecedented ventilation.

RIGHT: In contrast, thick "creeping" adhesive mass of conventional tape forms occlusive barrier, tends to plug widely spaced perforations, embeds and pulls hairs...contains irritating natural rubbers and resins.

APPLICATION: Unlike conventional adhesive tapes, new "SCOTCH" Surgical Tape does not slip or "creep" and should ordinarily be laid on without tension. Where tension is desired or anticipated, shear stress on the skin may be prevented by cross strips of "SCOTCH" Surgical Tape at the ends of primary application. AVAILABLE: through surgical supply dealers; in usual widths, ½ to 3 in., 10 yd. rolls.

MINNESOTA MINING AND MANUFACTURING COMPANY

3M COMPANY

...WHERE RESEARCH IS THE KEY TO TOMORROW

"SCOTCH" IS A REGISTERED TRADEMARK OF 3M CO.

SAVE space . . . hours . . . dollars with RECORDAK Microfilming

If space is a problem in your hospital, keep your case histories, other medical and business records on microfilm. Takes as little as *1% of space* needed for paper originals. Imagine keeping case histories by the thousand on a roll of film no larger than your hand! And these records are photo-accurate and tamper-proof . . . easy to refer to with a RECORDAK Film Reader.

If you are now losing hours on descriptive record-keeping operations, microfilming can help you eliminate manual posting and transcribing on job after job. Just one example: you can process patients' bills *4 times* faster by microfilming original requisitions . . . and sending them out with a simplified bill showing only total charges. This ends need for lengthy description. Many other "systems" applications possible.

If you want to save space, hours, and dollars in your hospital, look into the new RECORDAK RELIANT 500 Microfilmer—fastest, most efficient microfilmer ever built. In one minute, this trim unit photographs up to 500 items and indexes them on the film for fast, easy reference. Other Recordak models available for medium- and low-volume operations.

RECORDAK®
(Subsidiary of Eastman Kodak Company)
originator of modern microfilming
—now in its 33rd year
IN CANADA contact Recordak of Canada Ltd., Toronto

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SMALL HOSPITAL QUESTIONS

Where To Do Cesareans?

Question: We would like the help of your operating room consultant in a matter relating to surgical technic.

Last summer our chief of gynecology and obstetrics convinced our administrator of the necessity of doing all cesarean sections in the obstetrical department. Our O.B. section consists of three labor rooms, two delivery rooms, two nurseries, and an 18 bed postpartum section. The doctor's only reason for this decision was he did not want his patients taken from the O.B. section on first floor, through the halls of surgical floor (second floor), to the operating room suite. Our O.B. section is very isolated, with only authorized personnel there; and the only visitors are the husbands. The sterilizing in O.B. is done by the O.B. staff with the exception of the delivery pack, which is made up and sterilized in our central supply room. We average 384 deliveries yearly, and 12 cesareans.

The surgery division consists of three major rooms, one minor room, and one orthopedic room. We have very strict rules as to grooming and changing of uniforms and shoes, before entering the O. R. section.

Since the change in procedure, we have arranged for all equipment for a cesarean section to be kept in O.B. with the exception of instruments, suction machine, and necessary clamps. However, I still have a feeling of unrest and uncertainty during abdominal surgery in the O.B. section for the following reasons:

1. Delivery room and labor sections are not divided.

2. Three shifts of personnel on O.B. have to be familiarized with the procedure of cesarean sections (surgery supplies the scrub nurse only) while in surgery they are responsible for 24 hour call.

3. Delivery tables are too wide for abdominal surgery.

4. Possible chance of contamination from the labor room section.

5. Personnel on O. B. is responsible for nursery, postpartum, labor section, and delivery room section.

The present system has been reviewed by the infection committee and the only change was to have all the cesarean sections in the one delivery room that is used least of all. — M.M.H., Ill.

ANSWER: Despite all preaching and teaching to the contrary, a delivery room is a cleaner environment than an operating room. It is my view, shared by many others, that cesarean sections should be done where the patient will receive the best care in the safest environment. In my opinion, that is the delivery room.

I would suggest, however, that the operating room "on call" person should be called for the sections and be assisted by the delivery room staff unless you have developed other methods of augmenting the professional nurse coverage in the delivery room. I also strongly recommend that a complete set of instruments, a vapor-proof suction machine, and the necessary clamps be purchased and kept in the delivery room at all times. The instrument set may be assembled, wrapped and autoclaved for 30 minutes at 250 F. Following sterilization, the set can be enclosed in a clean, clear polyethelene bag and sealed. In this way it will be available and sterile when needed. — FRANCES GINSBERG, R.N.

What Nursing Coverage?

Question: Where can I find out how many registered nurses, nurse's aides, and orderlies are needed to cover a medical floor with a total of 28 beds?

I realize there are many influencing factors involved, but I would like to know what authorities believe is a suitable staffing pattern. — C.R.W., N.J.

ANSWER: I would suggest that you refer to Hospital Monograph Series No. 4, "Effect of Nurse Staffing on Satisfactions With Nursing Care," American Hospital Association, 1958, Appendix Table 2, p. 66.

This table shows that for hospitals with a daily average patient census of 100 to 199 on the medical floor an average of 3.8 nursing hours was provided for each patient during 24 hours. Professional nurses (R.N.'s) provided 1.7 hours of this and non-professional personnel (practical nurses, nurse's aides, and orderlies) provided 2.1 hours of the care.

One must be cautious in interpreting these figures as they are averages and not standards and do not reflect the individual needs of the institution. — FAYE G. ABDELLAH, *assistant chief, research grants branch, Division of Nursing, U. S. Public Health Service.*

New Procedure Acceptable

Question: We have always followed the procedure of keeping one end open in sterilizing cellophane catheter tubing. We were told recently that this is unnecessary, and would like to know if this is correct. — S.T., Minn.

ANSWER: Answering this question, our consultant in aseptic practice wrote as follows:

Earlier experimentation with cellophane catheter tubing pointed up the necessity to keep one end of the package open during sterilization. Studies of new tubing on the market, however, indicate that it is permeable to steam. Hence, one can safely close both ends of this tubing. Catheters should still be moistened before the tubing is threaded on the tab, however; when the catheter is enveloped in the tubing, the cellophane should not be pulled taut. Maintaining a loose, round lumen will reduce the possibility of the catheter's adhering to the tubing.

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 919 North Michigan Ave., Chicago 11.

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wire from Washington

H.E.W. CHANGES ARE ON THE WAY

For some time to come, hospital people had better keep their eyes on Washington. There are some changes on the way.

If anyone had any doubt how far and how fast President Kennedy planned to move in health and welfare fields, that doubt was removed with just two of his appointments — Wilbur Cohen as assistant secretary of the Department of Health, Education, and Welfare, assigned to legislation, and Alanson W. Willcox as general counsel of the department.

For both of them the appointments were a homecoming, and a vindication at the same time. Mr. Willcox had been general counsel of H.E.W.'s predecessor organization, the Federal Security Administration, and Mr. Cohen, head of research in F.S.A.'s social security administration when President Eisenhower took office in 1953. Because of their liberal views both of them were doomed, although it took the Republicans months to remove Mr. Cohen.

From his government job, Mr. Willcox moved over to that of general counsel for the American Hospital Association, a post he has held for the last eight years. In staff discussions and arguments within A.H.A., Mr. Willcox was identified with the liberals in most instances. For example, he favors medical care for the aged under social security, the Kennedy approach. He also has taken a liberal position on most other health and welfare issues, such as federal funds for building and operating medical schools. Outside these areas he is regarded by conservatives as "sound."

Mr. Cohen is known far and wide as a liberal among liberals in health and welfare. Every time a controversial issue has been up for congressional hearings, he could be depended upon to appear as a witness for the liberal point of view. He is well known to representatives and senators. Even those who can't find anything to agree with Mr. Cohen on admit that he is one of the best informed persons in the country on social security, and knows personally just about everyone of consequence in welfare work.

Mr. Cohen now is in a key spot, the kind of an appointment he has pointed for all his career and one in which he will have complete freedom to expend his crusading energy.

In the seven or so years he was out of government Mr. Cohen was professor of public welfare at the University of Michigan. Through his testimony in Washington and numerous speaking engagements, he has kept his name before the public constantly. **A week before his appointment was announced Mr. Cohen released the text of a report on federal health and medical problems, prepared by a Kennedy task force which he headed.**

Fitting the same pattern of outspoken liberalism is another new assistant H.E.W. secretary, former U.S. Rep. James M. Quigley of Pennsylvania, who was defeated in last November's election. Mr. Quigley is assigned to federal and state matters. All three will be serving under H.E.W. Secretary Abraham Ribicoff, who is closer to the center politically than any of them.

NEW PROGRAM FOR AGED DESCRIBED

As anticipated, Mr. Cohen's task force included medical care under social security as one of its many recommendations to President Kennedy. Not all details have been worked out, but the plan provides for payment of hospital bills and costs of the usual in-hospital services, but does not include payment of physicians' fees.

Unlike the Kennedy bill that was defeated in the Senate last summer, the Cohen program would offer benefits at age 65 to men and 62 to women who are covered by social security. The previous Kennedy plan set the eligibility at 69 years for both men and women. Doctor payments were ruled out for two reasons — to keep the costs down and as an answer to the American Medical Association charge that this type of program would mean socialization of the medical profession.

Benefits under the new proposal would go to about 14.5 million persons. Cost would be financed by increasing payroll taxes one-quarter of one per cent on employer and employe, and three-eighths of one per cent on the self-employed. Total cost is estimated at $1 billion annually at the start, leveling off at around $2 billion. (In contrast, cost to the federal government of the limited, nonsocial security medical care plan passed by Congress last year is expected to be approximately $200 million annually.)

Mr. Cohen said he expected hospital stays would be limited to 120 or 180 days. Also provided would be outpatient diagnostic services, skilled nursing home care, and home health services. Hospital benefits would be available a year after passage of the bill, but other services would not be offered for two years. Mr. Cohen explained that the time was needed to build more hospitals and train personnel.

To tool up for the additional services and the case load of elderly patients, the task force proposed that the federal government spend more money on medical research, and give grants to build and expand facilities and train physicians, dentists and nurses. There would be special provision for modernization or replacement of large urban hospitals. This also is an objective of the American Hospital Association, and has the support of President Kennedy.

A new approach to hospital financing also is suggested — grants to help pay the ordinary operating costs of hospitals, as well as to help in construction costs. Also recommended is a liberalizing of federal laws so medical schools

and other institutions would have the overhead costs of U.S. supported projects paid entirely by the government; now the institutions must meet most of these expenses.

In addition to matching grants for construction, Mr. Cohen's group suggested long-term, low-interest loans to hospitals and nursing homes, support for nurse training, and scholarships and loans to medical and dental students.

EISENHOWER CUTS HILL-BURTON FUNDS

Hospitals didn't fare so well in another document — Mr. Eisenhower's last budget. However, because President Kennedy's new department heads later in the year will make their own — and probably larger — recommendations to Congress, there is no real basis for concern.

As he has most times in the past, Mr. Eisenhower proposed that the Hill-Burton hospital construction funds be cut back. For the current year the program is spending $186,200,000 — considerably more than Mr. Eisenhower recommended to Congress. For the next fiscal year Mr. Eisenhower suggested $151,200,000, a reduction of $35 million.

The Eisenhower budget would continue most other federal health activities at their present spending rates, or increase the rates modestly. An exception is work on chronic disease and aging problems. On this, outgoing H.E.W. Secretary Flemming said:

"The program in the highly important and complex field of chronic disease and aging will focus on prevention of disability, an approach that promises the most rewarding return on the investment in this field. The 1962 budget includes an increase of $612,400 for this activity, including the initiation of a program to demonstrate to communities the feasibility of providing nursing services for the sick and disabled persons at home.

"In addition, emphasis will be placed on the development of coordinated and comprehensive community health services for the aged and chronically ill."

PROBLEMS OF AGED GET GOING OVER

For four long and busy days all the health and other problems of the aged were argued, reargued, voted on, and reported on by 3000 delegates who came from every state and territory to the first White House Conference on Aging.

It was a frantic and often confusing session, spread out over scores of hotels and assembly rooms. But in the end a series of orderly "section reports" came out of the duplicating machines.

Although much was made of these reports in newspapers — where they generally were identified as "conference recommendations" — they are actually only the expressions of the separate sessions. All of the voting and most of the arguing was confined to these groups. For example, one section voted 170 to 99 in favor of the social security approach to medical care for the aged. This generally was interpreted as the action of the conference, whereas actually it was an issue debated and voted on by fewer than 10 per cent of the delegates.

Dr. Edwin L. Crosby, executive vice president of the American Hospital Association, set the tone for the medical care section's findings regarding institutional care. "Our task," he said, "can be capsuled into a single objective. It is this. We must decide how to provide institutional care to those who need it so that the right person is getting the right care — at the right time, at the right place, and at the right cost."

Amplifying his views, he argued that every effort should be made not to separate the aged from the rest of the population any more than necessary. He also checked back to physicians the responsibility for guaranteeing old people the right care. "I cannot emphasize too strongly," he declared, "the role of the doctor in seeing to it that the aged person gets the right kind of care at the right time. The institution ultimately can do only what the physician directs. . . ."

The part of the final report devoted to institutional care makes these points:

1. Institutional care should encourage self-reliance and "preserve personal dignity," and should be provided "in a manner which does not discourage care in the home but ensures that such care is given at the right time and in the right place."

2. The quality of care in many institutions cannot be defended; licensing laws must be adequate for protection and must be rigorously enforced.

3. While everything possible should be done to encourage voluntary prepayment programs to extend coverage to aged individuals, and to cover the whole medical care spectrum, "local, state and federal financing will be required in increasing amounts to supplement individual resources and voluntary prepayment."

4. Needed care must not be denied because of inability to pay.

This group also became embroiled in an argument over medical care under social security. Eventually it voted against such a program, but the action was stricken from the record through the conference chairman's ruling that this was not within the section's province. The final report did contain the following words, much to the disgust of proponents of social security medical care: "Existing federal-state matching programs will provide effective, economical, dignified medical care for our elderly citizens who need help. The implementation of such programs should result in the high quality of medical care desired. Compulsory health care inevitably results in poor quality health care."

The stricken sentence, which immediately followed these words, stated: "Therefore we feel that health care under the social security mechanism would be unnecessary and undesirable."

Dr. Luther Terry Named Surgeon General

PALM BEACH, FLA. — Dr. Luther Terry of Rockville, Md., is the new P.H.S. surgeon general. Dr. Terry, one of President Kennedy's last pre-inauguration appointees, was assistant director of the National Heart Institute, Bethesda, Md., and a faculty member at Johns Hopkins medical school, Baltimore. At 49, Dr. Terry is a veteran Public Health Service employe, having served in various positions at the National Heart Institute since 1943 and, earlier, as chief of medical services at the P.H.S. hospital in Baltimore.

The Modern Hospital
FEBRUARY 1961

LOOKING AROUND

Candy Kids

A NICE man called up the Children's Medical Center in Boston not long ago. He'd been thinking about making a contribution to the hospital, he said, and had decided he'd like to furnish the lollipops that are handed out to patients. Could someone tell him about how many lollipops the hospital used in a year?

Someone could: Ninety-three thousand.

Testing

ENCOURAGED by cost conscious trustees, administrators and salesmen on commission, such cybernetic dazzlers as computers and transducers are settling down for a long stay in hospitals. Although some employes will probably move over, few are expected to move out and, even with more dials, levers and perforated tape around, no one seems likely to suffer – least of all the patient.

Certainly, good employes can relax; their value will increase, if past lessons from automation mean anything. The man or woman who can produce is always in demand – and never more so than in today's hospitals, where rising salary scales now permit an increasing number of administrators to get off their knees and pick and choose among available job candidates.

Whether they use common sense, clairvoyance or a ouija board, alert administrators soon learn how to recognize and hire people with ability and potential. Mastering this, they move on to the art of making successful promotions, an especially complicated process in hospitals, where many of the disciplines involved train people to serve rather than to supervise. In such a setting it is easy to miss twice with one promotion and weaken two positions; on occasion the best of managers can confuse bedpan efficiency with deadpan efficiency and turn a good floor nurse into a poor head nurse.

Here clearly is an area where an administrator can use all the help he can get, we thought the other day as we prepared to audit a symposium on testing for executive ability. For two days at the University of Chicago we sat with 50 hospital administrators, educators and officials and heard an expert explain what was good and bad about psychological testing. What was good about the tests was that they apparently help executives guess right more often than not in appraising employes. What was bad about them, it turned out, was that validation studies were hard to come by and no one really seemed to know exactly how helpful the tests were.

Convinced as we are that eavesdroppers, wiretappers and one-way mirrors have left few things sacred and nothing secret, we were not surprised to learn that some of the more sophisticated tests don't look like tests at all but take on the appearance of an ordinary application blank – a blank so artfully structured that, in the hands of an expert interpreter, it can become a clinical instrument.

Whether the tests are, in the black words of William Whyte, "an inquisition into the psyche," or a progressive milestone in employment practice, it is apparent that they have caught on with industry. Food chains, telephone companies, automobile manufacturers, and even publishing firms, as we have had occasion to find out, now lean heavily on them for guidance. Batteries of tests have been assembled to measure the executive ability of everyone from pinboy to president, and in many companies no one is hired, promoted or transferred until the decision is supported, or at least accompanied, by a thorough psychological report.

Although the costs of such tests are considerable, industry plainly finds them worth the price, and the implications are clear for hospitals, where labor costs have always wrapped a strait jacket around the heavy end of the budget.

Now, what did you say that ink blot resembled?

Bargain

WHAT a new hospital building does for patients is fairly clear: It makes it possible for physicians to give them better care. Invariably, the new building has facilities that old buildings lack. The patient undergoing commissurotomy might not survive in a drafty old surgical amphitheater. The new hospital also speeds

recovery by providing psychologic support, as many patients who have been sick in both old and new buildings have testified.

Another new building that is performing a substantive service for hospital patients, it occurred to us during the midyear meetings of the American Hospital Association a few days ago, is the new A.H.A. headquarters in Chicago — a monument whose financing and construction involved a certain amount of anguish, it will be recalled. Prowling around the meetings, a reporter had an opportunity to observe the building hard at work. Trustees, councils and committees conferred simultaneously in board, committee and assembly rooms planned specifically for the purpose. Moreover, these groups adjourned for lunch and dinner and reconvened promptly without the loss of time and attention that is inevitable when conferees are deployed around in hotels.

While there are meetings of one kind or another going on at A.H.A. headquarters most of the time and the built-in efficiency thus makes a continuing contribution to the work of the association, another improvement attributable to the new building has been in the day-in, day-out performance of the staffs. Good people like good surroundings, and the building has thus been an aid in staff recruitment and a brake on turnover, it is reported, notwithstanding the tendency of the new heating and air-conditioning equipment, after the perverse fashion of many mechanical marvels in our time, to bite back on occasion. Moreover, as administrators know better than most others, productivity requires more than bodies on the premises; it depends heavily on the will to work, which is largely a product of morale. As a new hat makes a woman's spirits soar, the bright new building has lifted A.H.A. morale; one sharp-eyed observer has even reported that secretarial and stenographic seams are straighter than they were in the old headquarters — an index of productivity that is considered significant, if not precise.

Some of the committee rooms and offices of senior staff members have carpeting, paneling and furnishings that are not exactly austere — a circumstance that has caused raised eyebrows in the diminishing school of hospital thought which holds that the nonprofit concept is inconsistent with attractive decor and demands linoleum on the floors and battleship gray on the walls. Happily, the prevailing view is that important work requires a pleasant and efficient environment. In their own hospitals, administrators have found that they can deal more effectively with medical staff, department heads, and others in offices that bespeak dignity and authority. Conferences that begin with everybody dragging in his own chair and end with the chief surgeon perched on the radiator can easily generate an acrimony that may owe something to the discomfort of the participants. The wheels of charity, like those of commerce, turn more smoothly in upholstered chairs.

It is too bad, perhaps, that we are stuck with a value system in which a man's authority is measured by the size of his desk and the length of his draperies, and an institution's by the shape of its silhouette and the speed of its elevators. But this *is* the system we have, and most hospital people are pleased that their association has now found its proper place on the value scale. In fact, many of those who originally opposed the building plan as extravagant and the dues increases as excessive have reversed themselves and joined the rest of the membership singing hosannas for the new headquarters.

Whatever the members think, it is the nation's hospital patients who are paying for the new A.H.A. building — as they do, ultimately, for all the new hospitals. In both cases, they are getting their money's worth.

Impact

IN A recent survey, the impact of 30 separate governmental health programs on 10 voluntary hospitals in New York State was studied in relation to patient care, hospital staff, administrative practice, financial support, and development of services and facilities.* On balance, hospital administrators were found to be living contentedly with a great variety of governmental programs. There were some apprehensions about government, but analysis showed these emerged largely from suspicions about the future rather than from actual experience, the authors said.

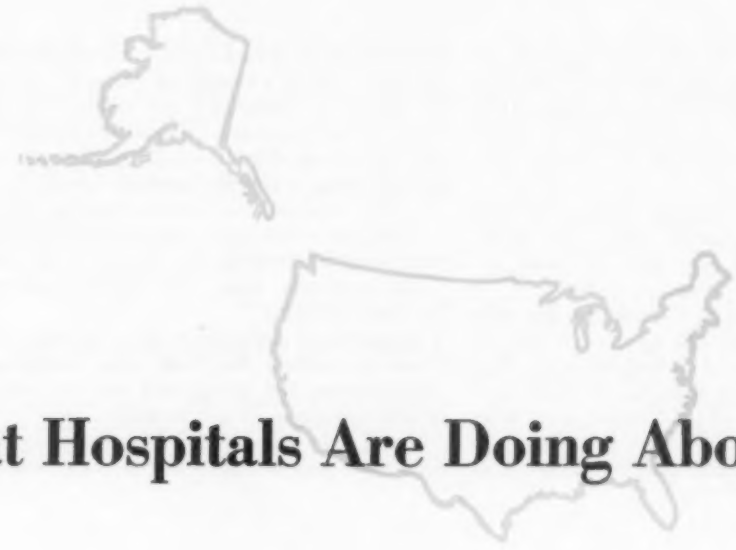
Regarding beneficiary payments by government agencies, hospital representatives reported no problems at all with federal programs and described cooperation between hospital staffs and government officials as very good or good. State beneficiary programs were also considered satisfactory. The effects of local government beneficiary programs were more noticeable, with some administrators reporting that the programs exercised control over hospital operations and some complaints about rates of payment for beneficiaries. Three hospitals reported relationships with government officials as "only fair."

General financial assistance programs by federal, state and local governments were described favorably. One administrator, however, thought construction standards in the Hill-Burton program were "excessively demanding." Regulatory programs conducted by federal, state and local governments were described in detail, with occasional objections emerging in connection with inspections by the state social welfare department. Nursery and school of nursing standards were also considered objectionable by some. Several hospitals in the group complained about competition with government hospital services — notably the Veterans Administration. One hospital complained about competition with a state rehabilitation center.

"Much that is said about the influence of government on voluntary institutions in American life is manifestly based on an *a priori* ideology and anxiety about the future, rather than on objective observation today," the authors concluded.

"Whether a great extension of governmental impacts on voluntary hospitals in the future would alter the evaluations of administrators is another matter. . . . It is our hope to pursue this question with a larger sample of voluntary general hospitals, in various parts of the United States. It is hoped also to explore the impacts of government beyond their perceptions by administrators and down to their measurable consequences in actual hospital operation."

*Milton I. Roemer, M.D., and Mary Helen McClanahan, M.A.: Impact of Government Programs on Voluntary Hospitals, Pub. Health Rep., 75:537 (June) 1960.



What Hospitals Are Doing About Unions

Aaron Cohodes

Hospitals and unions are playing a waiting game, with each group nervously watching the other, this national report indicates

Your Move.

That's what hospitals and unions appear to be telling each other while the bruises heal from last year's organization drives in the health field.

Like Macy's and Gimbels, neither group is eager to talk for publication about future plans. It's clear, though, that both are switching to fresh strategy based on lessons learned from last year's vigorous organizing efforts, which resulted in few clear-cut victories for unions — or for hospitals.

If anyone was a victor, it appeared to be the hospital nonprofessional employe. More likely than not, he found his starting salary raised, his fringe benefits increased, his job described, and his grievance procedure clearly outlined and explained. He — or she — never had it so good. And it's our doing, grumble the unions, which claim that their aggressive efforts forced hospitals to sweeten their personnel policies, a charge that appears to have some foundation.

Whatever the incentive, hospitals all over the country are pulling up their salary scales and wading into enlightened personnel programs that, in most cases, are turning out to be less formidable than anticipated. National, state, regional, metropolitan and local hospital associations are hustling around outdoing each other in

staging personnel institutes. Seminars or discussions on how to develop written personnel policies, job descriptions, job analyses, grievance procedures, and technics for defeating organization attempts are taking place in virtually every state – even those that as yet have felt no pressure from unions.

While this is happening, unions have made a few mild forays into such disparate places as Jasper, Ala., Boise, Idaho, and Gary, Ind., where they have been easily rebuffed – to the surprise and occasional confusion of the hospitals involved. In Gary, the Building Service Employes Union, Local 208, announced with considerable fanfare its intent to organize employes of all hospitals in the area. After meeting unified resistance from the hospitals, however, the local hastily backed off and has been quiet since. In this instance, timing may have been as important in the union's failure as the united stance of the hospitals. Steel mills in the area have been running far below capacity, thus creating a scarcity of jobs and a lot of problems for the union, which must still collect dues and provide funds for hardship cases. The rise in unemployment across the country probably is one big factor behind the softening of organizing efforts in hospitals; taking on a hospital campaign is expensive, time consuming, and as risky as roulette, something that union locals in Chicago, Cleveland, Seattle, Indianapolis, Buffalo, Colorado Springs, Jasper, Baltimore, Boise, Gary and St. Louis learned the hard way in 1960.

Reports from across the country reaching The MODERN HOSPITAL indicate that, with some exceptions, hospital administrators and officials still feel that unionization of hospital employes is not necessary, wise or inevitable. The way to keep unions out of hospitals, suggests one hospital association official, is to improve personnel practices

WHAT UNIONS ARE DOING ABOUT HOSPITALS

CHICAGO. – This year, legislation in a few key states may do for organized labor what threats, walkouts and strikes could not do: compel voluntary hospitals to bargain with unions. Bills that would in effect accomplish this are expected to be introduced at state legislatures now meeting in New York, Illinois, Utah – and probably in several other states.

In Illinois, a task force of three unions with one unsuccessful invasion of Chicago hospitals already on its record stands ready to move in again at the first passing of a favorable state labor relations act. Now, while the legislature is still in session, the unions are adopting a wait and see attitude.

"We have to," explains Victor Gotbaum, director of Local 1657, American Federation of State, County, and Municipal Employees Union. "All our hopes for organizing Chicago hospitals depend on what the state legislature does."

In defending last year's bitter five-month strike at Chicago's Mount Sinai Hospital and the Chicago Home for Incurables, which Local 1657 staged, Mr. Gotbaum said that it proved a point – "and it was a good point; hospital employes' salaries went up 11 per cent in the Chicago area." But enough is enough for Mr. Gotbaum – without a law to compel hospitals to recognize the union. "Organizing hospital employes is easy," he said. "Gaining recognition is something else again." To strike again under existing laws, he told The MODERN HOSPITAL, "would be the height of irresponsibility."

Poised on the sidelines, two other unions involved in the drive on Chicago hospitals – the Building Service Employes International, Local 73, and Local 743, Warehouse and Mail Order Employes (a Teamsters union affiliate) – are also keeping their hands close to their pamphlets, just in case. Although they no longer have hospital organization meetings, both locals keep in touch with "top people" in hospitals, the ones who will become shop stewards when the hospitals are organized, according to union spokesmen.

Union officials indicate they are confident they will be able to expand their hospital memberships.

"It's only a matter of time," a Chicago Teamsters official says. "More attention is being given to hospitals every day – even the Bureau of Labor Statistics considers them a big business just like everything else," he added, possibly alluding to the recent salary survey completed by the bureau (page 96).

In New York, where a strike hit seven hospitals a few years ago, unions are now campaigning to bring hospitals within the provisions of unemployment insurance and state labor relations statutes.

Local 1199 of the Retail Drug Employees Union – the union that struck seven voluntary hospitals here in April 1959 – reports that recruiting still goes on all the time and claims to have 8000 hospital employe members in 22 institutions in the New York metropolitan area, an assertion which, if true, would make it the largest local of hospital employes in the country. (Local 250 of the B.S.E.I.U., in San Francisco, often considered to be the largest, claims to represent "upwards of 7000 members.") According to a union spokesman, 3200 members of the union are in nine institutions that have contracts with Local 1199, which reports it is now seeking contracts with three additional hospitals. The nine institutions already in the fold:

and "remove as far as possible the conditions that lead to unionization."

Here, by region, is what hospitals across the country are doing to remove these conditions.

NEW ENGLAND

(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Although not confronted with a formidable union invasion in recent years, hospitals in this area are looking ahead with concern rather than complacency. *Connecticut* hospitals, which through their association employed a full-time personnel specialist for several years in the 1950's, before they were fashionable, are now well along with wage administration and job evaluation programs. Alert to the dangers of a wildcat type of strike, the state association has a labor relations counsel standing by watching developments in neighboring states, such as *New York*.

New England hospitals have been working hard to raise salary scales and fringe benefits to correspond with those in other local industries; in *Massachusetts*, encouraged by the state association, two trustee committees have been appointed to improve wages and working conditions.

In *Rhode Island*, the state nurses' association took a step toward acting as a bargaining agent last year by sending out a list of minimum employment standards for general duty nurses. The standards are slightly more liberal than prevailing practices in the area but, it is reported, the

Montefiore, Maimonides, Trafalgar, New York University Medical Center, Home and Hospital of Daughters of Jacob, Home and Hospital of Daughters of Israel, Beth Abraham, Home of Old Israel, and the Odd Fellows Home.

In these institutions, the spokesman reported, the established grievance procedure is working satisfactorily, an assessment that agrees with reports from hospitals (see hospital report, page 84).

Like the Chicago unions, Local 1199 takes credit for wage increases in hospitals. Since the 1959 strike hospital wages have been advanced to a minimum of $45 a week, in most cases, from the $32 to $38 that prevailed in many hospitals at the time of the strike. The minimum at Mount Sinai, for example, is reportedly now $50 a week.

The state labor law has already been amended so that voluntary hospitals are included under the $1 an hour minimum wage provision. Hospital employes are also covered for state disability benefits, and, as has been mentioned, the union is now campaigning hard to force hospitals by statute to bargain with unions.

The position of management toward unionization of hospital employes in the seven hospitals that were struck in 1959 remains "essentially unchanged," the spokesman for Local 1199 reported. However, he said, hospital management elsewhere is more approachable now than it was then.

Citing communications from unions in Buffalo, Chicago, San Francisco, and Minneapolis in recent months, the spokesman indicated that Local 1199 is constantly asked for information and advice by unions seeking to organize hospital employes.

As a teaching aid the Local has put together a documentary film based on the 1959 strike. It is on 16 mm. sound film, takes about 20 minutes to show, and is available for showing by unions anywhere. The film has been actively circulated in the East and on the West Coast, and is expected in Chicago some time this month.

While it has not as yet made any instructional films, the national headquarters of the Building Service Employes International Union sends out a steady stream of organizing leaflets and other literature for use by locals in hospital campaigns. Recently, to help affiliated local unions that are planning to organize hospital employes, the union distributed a detailed report of wages paid and hours worked in state operated general, mental and tuberculosis hospitals in 41 states.

Although B.S.E.I.U. officials will not disclose how many of its members in the United States are hospital employes, they did indicate that in Canada, where hospitals by law must bargain with the union chosen by employes, 10,000 of the union's 14,000 members are hospital employes.

"We are not shooting at hospitals because they are hospitals," said George Fairchild, secretary-treasurer of B.S.E.I.U., "but they're certainly vulnerable."

Hospital workers, public employes, and farm workers are the three largest unorganized groups in the country, he points out, and "unions organize the unorganized."

As the accompanying report shows, however, hospitals no longer can be classified as sitting ducks for unionization. For the most part, they are indeed unorganized — but far from disorganized in their attempts to stay that way. ■

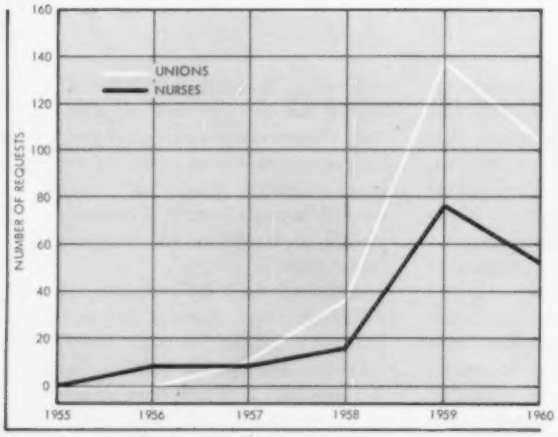
statement has been offered and received "in the spirit of advice and encouragement rather than as a formal demand."

Regional summary: No union activity but lots of hospital personnel progress.

MIDDLE ATLANTIC

(New Jersey, New York, and Pennsylvania)

Following the tumultuous organization activity in New York City hospitals, which in recent years have experienced strikes, threats and lawsuits, organizing campaigns have become fewer and milder, although union sources claim they are still going on (see report, page 82). The Permanent Administrative Committee that was established following the 1959 strike in seven voluntary hospitals now consists exclusively of six members representing the public. This committee works with two advisory groups without voting power – one representing labor and one representing hospitals. The committee also serves as the mediation and arbitration agency for grievances.



Collective bargaining requests tapered off last year after a sharp climb every year since 1955, according to American Hospital Association estimates by Edward Weimer, secretary, A.H.A. Committee on Personnel Administration.

At one Manhattan hospital where a contract with Local 1199 was signed early in 1960, the administrator reported last month that the institution was pleased with the arrangement. "Our people, and especially those in personnel and supervisory positions, have had to adjust to new ways of doing things," he told The MODERN HOSPITAL, "but we haven't had any serious problems and have found the union helpful on many occasions."

Several cases have come up for consideration under the grievance procedure stipulated in the hospital contract, which includes a permanent "no strike" pledge on the part of the union, it was reported. In cases of firings due to habitual tardiness or incompetence, the union withdrew its objection as soon as all the facts were presented in conference, the administrator said. In one or two cases, he added, the hospital changed its position after full information on the dispute had been considered.

The Permanent Administrative Committee's first report, which ran more than 100 pages, handed out recommendations concerning wage levels, job grades, hours, grievance handling, seniority and related employe benefits, and was well received by subscribing hospitals. Virtually all of them have accepted the recommendations, at least in principle. The committee has been carefully checking each hospital's 1960 financial report against its report of actual or proposed changes in wage matters and other personnel policies to assure that hospitals are carrying out the recommendations.

In addition, a professional advisory committee has been formed from the central labor council's hospital and medical care committee. According to the *New York Times*, this committee "represents a promised effort to bring the critics

(labor) and the criticized (hospitals) together – both to give labor a better knowledge of the practical problems involved in curbing the high cost of health and to enlist professional cooperation in dealing with these problems most effectively."

In western *New York*, the regional hospital council has developed a complete wage and salary administration program, which hospitals are now implementing at varying speeds. Although some hospitals in the region are not yet participating in the program – thus weakening its total effect – most already subscribe to its policies, such as a $1.10 minimum hourly wage, time-and-a-half for overtime, and $1000 free group life insurance.

While the labor unrest in *New York* has not spread across the river to *New Jersey*, hospitals there are doing what they can to anticipate such a move. The state association has organized an advisory committee of five personnel experts from industry to work with the council on administrative practice and its subcommittee on personnel administration. First project, produced with the help of industrial relations counselors, was a 45 page manual on "Essentials of Personnel Policies and Relevant Procedures for New Jersey Hospitals." Also planned is a wage and salary administration manual that includes job descriptions and instructions on how to evaluate hospital jobs and conduct surveys of local wage rates.

In *Pennsylvania*, where nonprofit hospitals are exempt from collective bargaining by the state labor relations act, labor unions at present appear to be more interested in obtaining comprehensive prepaid health care at low cost for existing members than in extending union membership to hospital employes. "Conceivably," one hospital official noted, "some unions recognize that one objective might conflict with the other." Heavy layoffs of personnel from the steel mills have also kept union locals busy doing housekeeping duties among members they already have.

Hospitals here are moving toward a $1 an hour minimum pay scale and, especially in the western *Pennsylvania* area, are installing systematic salary classification plans based upon job evaluations.

Regional summary: Hospitals are moving fast to lessen the appeal of unions – but it probably will be hard to contain them in New York City.

SOUTH ATLANTIC

(Delaware, Florida, Georgia, South Carolina, Virginia, Maryland, North Carolina, West Virginia, and District of Columbia)

Virtually every attempt to organize voluntary hospitals in this area has fizzled, including a low-pressure attempt in *Maryland* at three large hospitals where the union leader soon surrendered to a stiff hospital position briskly expounded by Dr. Russell A. Nelson, director of Johns Hopkins Hospital, one of the institutions involved.

Observers predict, however, that the present period of quiet and union frustration is only an intermission. Although Baltimore has a reputation for being a conservative labor city, a renewed organizational assault is expected in 1961. Meanwhile, the hospitals are working together to correct the conditions that lead to unionization. In the Washington, D.C., area, where two hospitals have had labor contracts for many years, no other drives have been reported since the local restaurant workers unsuccessfully attempted to organize dietary workers at Georgetown University Hospital.

In the South, United Mine Workers hospitals are unionized and an occasional unionized nonprofit hospital turns up – usually having been organized for many years. No trend toward hospital unionization has been observed here, perhaps because many large industries, such as the textile industry, are virtually free of unionization. Although salaries in some areas here still are lower than the national average (see report on page 96), associations and informed trustees are making an effort to correct this situation so that hospitals cannot be used as the opening wedge into the South by union organizers.

Regional summary: Hospitals seem to feel less urgency, slightly less apprehension than their Northern neighbors.

SOUTH CENTRAL

(Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma and Texas)

Here the situation is similar to that in South Atlantic states. In *Oklahoma* an attempt was made to organize nonprofessional personnel in a state mental hospital. A committee of the state legislature investigated and recommended, at least by implication, that the state mental health board should not recognize the union.

In *Mississippi*, where the state nurses' association has tried several times to implement its economic security program, the state attorney general recently prohibited governmental hospitals from entering into collective bargaining processes. Most hospitals in the state are of this category, and, as one official put it, "even if the M.S.N.A. hires a two-headed monster, we believe we have them stopped now."

In *Louisiana*, the state hospital association sent a statement of policy to all member hospitals urging them to adopt modern and liberal personnel policies. Institutes on personnel policies are being scheduled here and in *Mississippi*, *Texas* and elsewhere in the South.

Regional summary: Situation apparently under control.

(Continued on Next Page)

EAST NORTH CENTRAL

(Illinois, Indiana, Michigan, Ohio, Wisconsin)

Hospitals here are off and running on improved personnel programs. *Illinois* hospitals, which are now exempt from collective bargaining, have blunted thrusts of unions and of the Illinois Nurses' Association; both have made several bids to obtain recognition as bargaining agents, but are now busy plugging for a state labor relations act that includes hospitals. During the lull hospitals are responding as state and local associations hammer home the importance of improving working conditions irrespective of union pressure. Two new regional organizations of personnel directors are now affiliated with the Illinois Hospital Association; both stimulate and inform hospitals on personnel matters. More hospitals are hiring persons with some professional background in personnel administration, which "makes a great deal of sense in terms of plain economics," explains David Kinzer, executive director, Illinois Hospital Association.

A uniform approach to the problem, sparked by the local association, is also evident in Chicago, where hourly pay rates have been raised to a $1.13 minimum and there is talk of raising them even higher to seize the initiative from the unions, which now take credit for all progress in this area (see union report, page 82).

In *Wisconsin*, where by state law hospitals must bargain with unions, most of the inroads have been made by the state nursing association, which has contracts with some 20 hospitals. Mount Sinai Hospital, reportedly the only nonprofit hospital in Milwaukee with a union contract, is currently negotiating a new contract with Local 1572 of the Hospital and Nursing Home Employes Association (American Federation of State, County, Municipal Employes). Experience with the union, which has a closed shop there, has been "reasonably satisfactory," according to a hospital spokesman.

Although the outcome has not as yet been clearly settled, Building Service Employes, Local 59, reportedly has won recognition as a bargaining agent for nonprofessional employes of Lutheran Hospital, LaCrosse, Wis.

In December, action in *Ohio* focused on Cleveland, where a local union, Hospital Workers' Local 500, staged a messy fight to obtain recognition at Huron Road Hospital. Picketing of the hospital was stopped by court order and a subsequent bombing of hospital workers' cars resulted in the jailing of two union leaders.

In banning the picketing, Judge Daniel Wasserman took a strong stand. "It doesn't make any difference if *New York* or all the other states permit picketing of a hospital," he said, according to the *Cleveland Press*. "As long as I'm on the bench I won't permit it."

Michigan, and especially Detroit, a union stronghold, serves up several unusual labor problems to hospitals. Some Detroit municipal hospitals have unions, and probably all Detroit hospitals employ maintenance men who are in unions; most trade workers here join a union at some time and do not drop out even if they are no longer active. Three small Negro hospitals in Detroit reportedly have signed contracts with A.F.S.C.M.E. upon recommendation of a three-man commission appointed by the governor. In a test case that has hospitals throughout the state watching nervously, well known Oakwood Hospital in Dearborn has gone to court to test whether a hospital has to recognize a union in *Michigan*. The existing law, as one hospital official wearily noted, is so ambiguous, "no one really knows what it says." Oakwood Hospital at present is being pursued by Local 1644 of the A.F.S.C.M.E., which won a court-ordered strike vote but did not strike.

Oakwood *versus* the union, says one official, "pits a good strong hospital, well able to fend for itself, against a union that so far has used only legal measures in its fight. There has been very little publicity, because nothing sensational ever happens. So far, it's a Mozart minuet – everything according to form."

Regional summary: Still touch and go with both sides digging in.

WEST NORTH CENTRAL

(Kansas, Iowa, Minnesota, Nebraska, North Dakota, South Dakota, Missouri)

Most recent trouble spot in this area has been St. Louis, where the Building Service Employes International Union is striving to organize nonprofessional workers at Barnes Hospital – but reportedly with little success. The union, however, claims to have more than half of the 1200 Barnes Hospital employes signed up. So far the hospital has refused to recognize the union or negotiate with it, and, at press time, no activity by the union had been noted in several months.

Elsewhere in the area, labor relations seem unchanged. Three hospitals in Kansas City still retain union contracts with engineers, something they have done for more than 20 years, but the movement has not spread to other hospitals, nor does there seem to be any effort to spread it.

Minnesota hospital officials continue to spend many days at the bargaining table and many nights worrying about the days. Big problem facing Minneapolis-St. Paul during 1960 was a new contract between 19 hospitals and Public Building Service and Hospital and Institutional Employes Union, Local 113 (A.F.L.-C.I.O.).

Lengthy negotiations between 11 Minneapolis hospitals and the local proved unfruitful. In lieu of a strike against the hospitals – prohibited under *Minnesota* law – the issues were handed to a special arbitration panel, whose chairman was appointed by the governor. Among the benefits granted after 16 days of hearings: wage increases for

1960 (7 cents – retroactive to March 1), 1961 (7 cents), and 1962 (6.5 cents).

Last month, six hospitals in St. Paul arbitrated their contract with the same union and reached the same cost conclusions in substantially the same language used in the Minneapolis settlement.

Two more hospital contracts, which terminated March 1, 1960, have neither been negotiated nor settled and remain as headaches.

During 1960, a two-year contract covering engineering personnel in four St. Paul hospitals was also negotiated. This contract is with Local 36 of the Operating Engineers Union. Basic settlements: wage increases of 13 cents and 12 cents on March 1, 1960, and March 1, 1961; extension of sick leave benefits to a maximum of 36 days accumulative from a previous maximum of 24 days.

When this round of bartering is over, hospital officials can breathe uneasily – and start making plans for 1961, when a two-year contract between 20 Twin City hospitals and the Minnesota Nurses' Association expires on May 31; a contract between 20 Twin City hospitals and the Minnesota Licensed Practical Nurses' Association expires on June 30; a contract between 10 Minneapolis hospitals and Local 34 of the Operating Engineers expires on February 28, and a contract between one Minneapolis hospital and the Public Building Service Local expires on February 28.

Regional summary: Neither hospitals nor unions are getting all they bargained for.

MOUNTAIN STATES

(Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah and Wyoming)

Little organizing effort reported here. In *Idaho* three state hospitals were approached but union interest subsided quickly when no encouragement was forthcoming from either hospitals or employes. In Boise, a representative of the International Union of Operating Engineers tried but failed to generate enthusiasm for the union among hospital engineers. As in 1959, the *Idaho* Hospital Association is preparing to fight a labor-introduced bill in the legislature that would force hospitals into collective bargaining practices and thus open the door for union organization.

Reversing a district court decision, the state supreme court in *Colorado* dealt a blow to unions in that state by ruling that a nonprofit voluntary hospital is exempt from the state labor act and does not have to bargain with unions.

In *Utah*, at least three hospitals (and probably no more) have union affiliation.

The Eldred Sunset Hospital (a custodial care institution contracting with Utah County for welfare cases) and the Utah State Mental Hospital, both in Provo, have entered into bargaining agreements with Local No. 50 of the American Federation of State, County and Municipal Employes, A.F.L.-C.I.O. The Utah Permanente Hospital at Dragerton (a Kaiser Steel coal mining area) has an agreement with the Retail Clerks Union, No. 13454, District 50.

Regional summary: Unions barking, but few bites reported.

PACIFIC COAST

(California, Oregon, Washington, Hawaii, Alaska)

Although all is fairly quiet on the Western front, few expect it to stay that way, least of all labor leaders. The nursing and hospital field is "our number one job in 1961," says Arthur T. Hare, Washington state representative of the B.S.E.I.U.

The hospital workers union in Washington, which is affiliated with the Building Service Employes International, still holds meetings, occasionally pickets a nursing home, but in general abides by terms of the Seattle Plan adopted at the conclusion of the Swedish Hospital strike last year. Patterned on the Toledo Plan, this arrangement makes union membership optional to hospital employes and provides for arbitration of grievances.

Local 250, Hospitals and Institutional Workers (B.S.E.I.U.), A.F.L.-C.I.O., continues to grow in the San Francisco area, and promises an "intensified drive" in hospitals this year. During the last year Local 250 claims to have organized the Presbyterian Medical Center and the Civic Center Hospital, and is now negotiating with Mount Zion Hospital. Other new contracts reported negotiated by the union: one with a new organization called the Voluntary Hospitals of San Francisco, consisting of Franklin, French and St. Francis hospitals, and one with the Affiliated Hospitals of San Francisco, a 10 hospital group organized to deal with Local 250; Local 39, International Union of Operating Engineers; Local 44, Cooks, Pastry Cooks and Assistants Union, and the California State Nurses' Association. Negotiations with the nurses association were accomplished last year without the aid of a professional negotiator by members of the Affiliated Hospitals group and representatives of the C.S.N.A. Negotiations with the other groups are carried on by members of a negotiating team working with a professional negotiator. Generally, relations between the hospitals and the negotiating organizations are good, according to one administrator, who added that "this type of organization has certainly been beneficial to the employes involved." But somebody must pay for these benefits, a point administrators and trustees have been known to make rather forcefully. In San Francisco, it's the patient or the third-party payer; hospital costs are perhaps higher here than any place in the nation.

Certain items, such as seniority clauses and a review of all discharges by the union, are asked for repeatedly by the unions, it is reported; so far, these items have been successfully kept out of a contract, however.

Regional summary: Still the best hospital-labor experience in the country. ■

Medicine and engineering combine their talents to produce an electronic surgical pavilion that provides unique facilities for special surgery

Automation Brings Boom to Special Surgery

Anthony J. Maranga

WHAT may well be the prototype for surgical facilities of the future is in operation today at St. Barnabas Hospital for Chronic Diseases, New York City. Literally made to order for the surgical staff, the Kane Surgical Center (built on top of the Kane Pavilion of the hospital) consists of four major operating rooms, plus the usual ancillary facilities and several that are not only unusual but unique.

Equipment Built to Order

The Kane Center, with its automated equipment, represents a triumph of communication between surgeons and the medical engineer employed to produce various items of equipment which the surgeons specified but which were not available commercially. Chief translator for the surgeons was the hospital's director of anesthesiology who is not only an M.D. but a graduate of Massachusetts Institute of Technology as well. His knowledge of medicine, coupled with his mechanical abilities, enabled him to make the surgeons' wishes comprehensible to the engineer, with resulting benefit to both parties and to the hospital.

Special features of the surgical suite include electrically operated recovery room doors; two complete intercommunicating systems, one of which centers on the recovery room; conductive ceramic tile floors in all surgeries, and portable aspiration and resuscitation mechanisms for all recovery room stretchers. These last were developed by the anesthesiologist and medical engineer.

Operating Room No. 3, devoted to special surgery and research, houses the most spectacular results of the collaboration between surgeons and engineer. The area incorporates not only the operating room proper but also the electronics laboratory, overhead electronics machine room, and anesthesia induction room. The equipment and layout were designed to (1) provide every conceivable type of patient monitoring device; (2) keep the operating room floor clear of all bulky equipment, and (3) allow for further instrumentation and equipment without cluttering the operating room.

To accomplish these objectives, a "pan" type of hanging ceiling was constructed. The concrete floor of the electronics machine room directly above contains two series of five removable slabs, measuring 2 feet by 2 feet each. This permits the overhead placement of different types of equipment so that they are actually suspended from the operating room ceiling (see this month's cover photograph). The space between the hanging ceiling and the electronics machine room floor accommodates countless leads for equipment and instrumentation located in the electronics laboratory. **Following is a description of some of the distinctive features of the area.**

Surgeon's Scott Boom: Attached to a mechanically movable horizontal arm leading from the electronics laboratory, this boom offers the surgeon a multiplicity of special equipment and services in a compact unit without overcrowding the operating room or presenting safety hazards. Equipment is housed in the electronics laboratory and operated by a resident engineer on instruction of the surgeon who makes actual connections from different leads available through a powered panel box on the end of the boom.

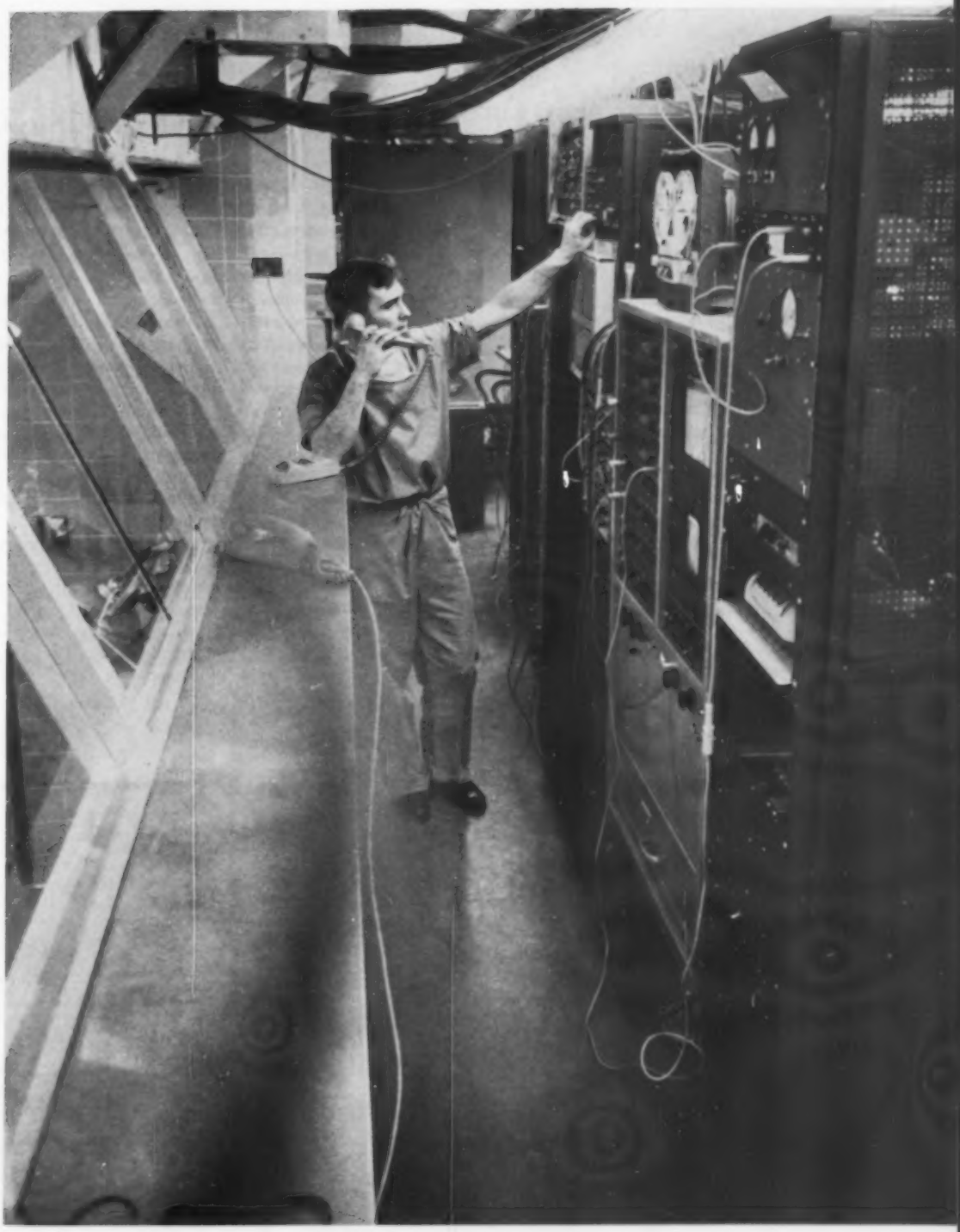
Box Moves Over Operating Field

The panel box, which has a removable sterile cover, can be lowered and raised overhead. It is movable over the entire operating field and also into the adjoining induction room through specially designed doors. Multi-color push buttons, operable from the sterile cover, may be manipulated by the surgical team to give instantaneous access to:

1. Thermostatically controlled warm sterile saline.
2. Remotely controlled electrocautery and electro-cutting.
3. Recorder connections for electrocardiograms, electroencephalograms, electromyograms and other measurements of patient response.
4. Electrostimulation connections.
5. Suction.

(*Text Continued on Page* 90)

Mr. Maranga is assistant director of St. Barnabas Hospital for Chronic Diseases, New York City.



The resident engineer supervises the electronics laboratory, which overlooks the special operating room at St. Barnabas. Panels monitor the induction of anesthesia; administration of hypothermia; electrocautery and electro-cutting; closed-circuit TV; oxygen analysis equipment; electrocephalography apparatus, and other electronic aids.

KYMOGRAPH MAKES PERMANENT RECORD OF VITAL SIGNS DURING SURGERY

(*Continued From Page* 88)

6. Switches to initiate and terminate monitoring devices.

7. Microphone and speaker for connection with the electronics laboratory and for tape recorders.

8. Timing devices, recorder switches, and time and event marker switches.

Connector outlets were also provided for possible future equipment and instrumentation.

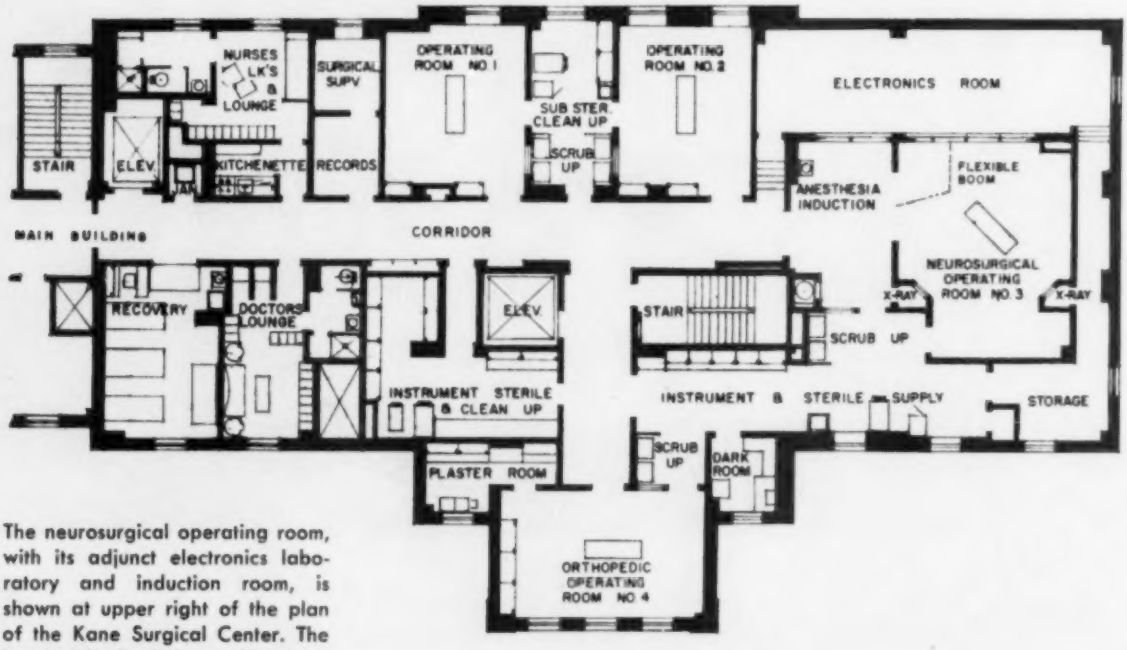
Oscilloscopes: An eight channel cathode ray oscilloscope is mounted on a vertical power boom through one of the removable slabs in the overhead machine room. Remotely controlled from the electronics laboratory, it is monitored to a smaller oscilloscope located in the laboratory, permitting permanent paper recordings to be made.

While the patient is undergoing surgery or anesthesia, the oscilloscope gives visible indication of many physiologic measurements, including electrocardiograms, electroencephalograms, electromyograms, blood pressure pulse waves, breathing characteristics, stimulation impulses, heart sounds, nerve impulses, and several others.

Kymograph: A 6 foot by 9 foot eight-channel kymograph screen is located on one wall of the operating room, permitting permanent two-hour and four-hour recordings of vital signs and time and events while the patient is undergoing surgery. Visible from any part of the operating room, induction room, and electronics laboratory, the kymograph traces the patient's blood pressure; blood, skin, esophageal, rectal or brain temperatures; respiratory rate and depth; concentration of inspiratory and expiratory oxygen, carbon dioxide, nitrous oxide, and other gases, and temperature of anesthetic inhalation agents. It also monitors the amounts of blood or drugs injected, as well as other significant factors during the surgical procedure.

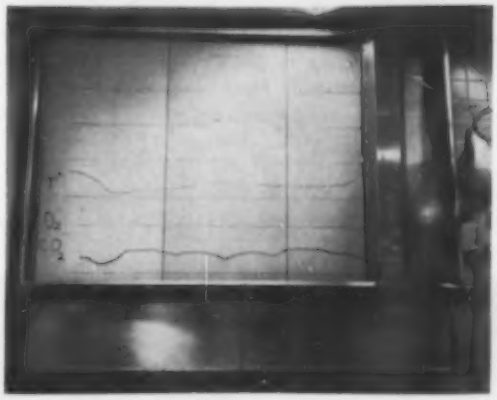
Inasmuch as tracings on the screen are large and therefore rather bulky for storage and future use, an 8 by 10 inch negative plate is made of all readings as part of the patient's permanent record.

Radiography: X-ray facilities are supplied through three stands which house remotely controlled x-ray tubes. Two of these are located in the northeast and southeast corners of the operating room, 12 feet away from the operating table. The tubes may



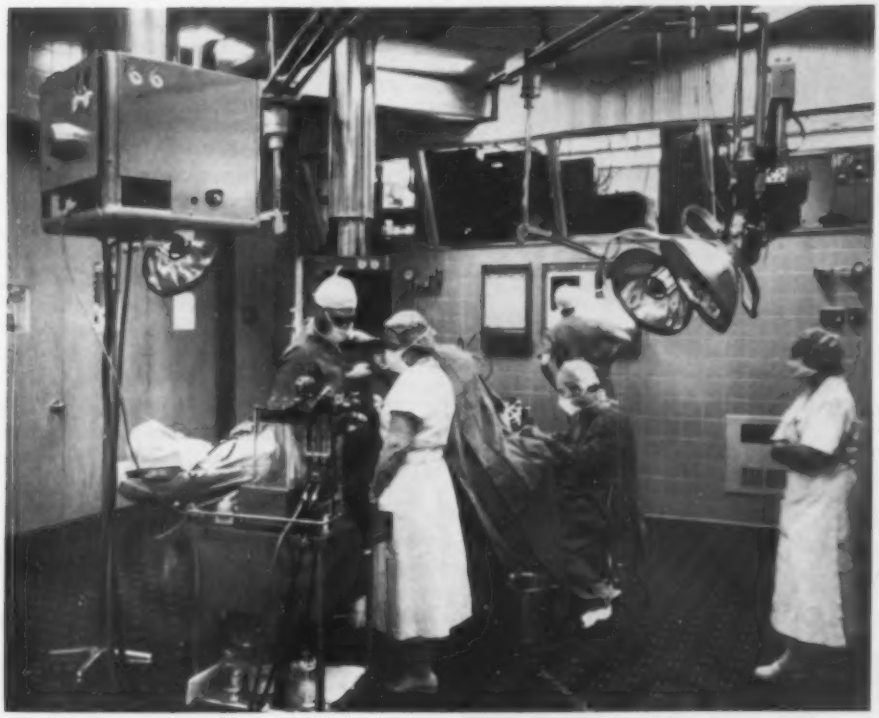
The neurosurgical operating room, with its adjunct electronics laboratory and induction room, is shown at upper right of the plan of the Kane Surgical Center. The hospital "raised the roof" of the Kane Pavilion to install the unit.

Right top: View from electronics machine room into special operating room through overhead x-ray tube stand opening in ceiling. Surgical Scott boom is directly above operating table. Buttons on the sterilizable cover of the boom bring everything the surgeon needs automatically within his reach.



Right, center: The 6 by 9 foot kymograph screen, which occupies a large part of one wall, records progress during surgery and serves as a minute-by-minute log of the operation. Tracings shown in photograph are simulated to show how it works.

Below: Table in left foreground in this view of the operating room (looking toward laboratory) contains the anesthesia machine. Directly above it is the oscilloscope. Leads from the anesthesiologist's supply panel underneath the oscilloscope are connected to the machine and the patient.

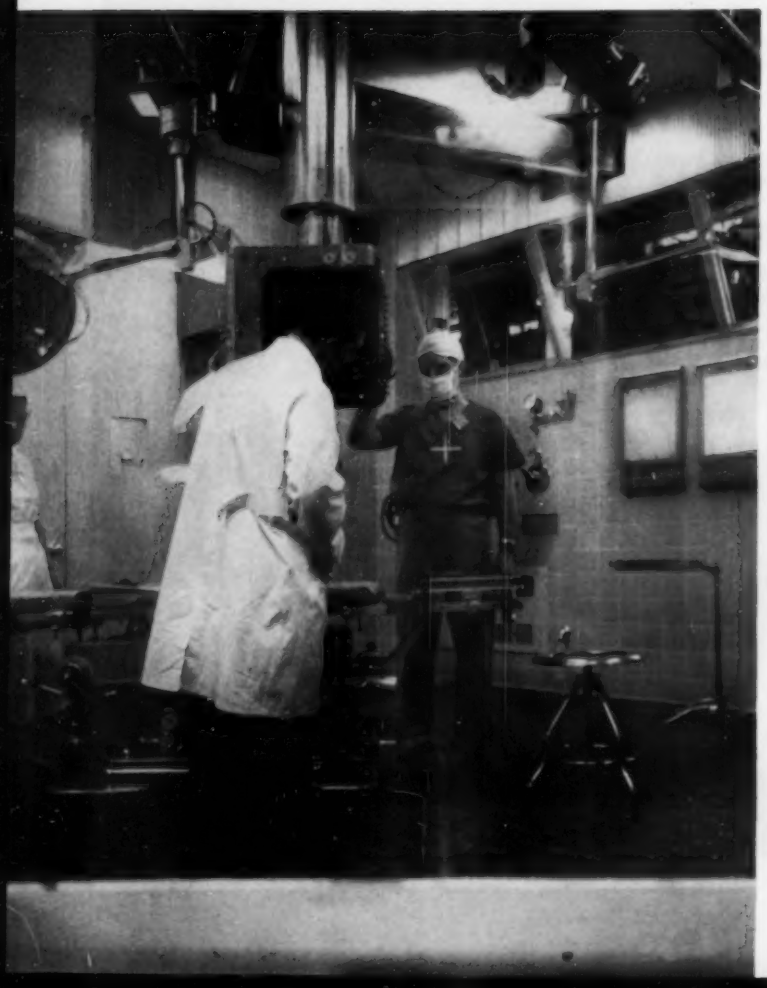


be directed up, down, to the left, and to the right. A third, located in the electronics machine room above, is 12 feet over the top of the operating table. This overhead x-ray tube is mounted on curved steel tracks to permit angulation of about 30 degrees. Accessible to the operating room through a 3 foot by 6 foot opening in the ceiling, it is movable horizontally and vertically, and may be tilted as well. Positioning of all three x-ray tubes is remotely controlled by one lever provided on the rear of the Scott boom.

Plastic glass "windows" on all three tube-stand enclosures offer clear visibility and prevent contaminated particles from entering the operating theater. High-powered by a single 500 milliampere generator, the tubes were placed to avoid obstruction to persons or equipment in surgery.

X-ray beams are sharply collimated and emit a minimum of scattered radiation. The center of the beam is delineated by a sharp bright cross of light. Specially designed cassette holders permit the taking of series of plates from any of the projections at short-time intervals. Because of the relative remoteness from x-ray tube to patient – the usual maximum is 6 feet as opposed to 12 feet under this design – greater radiographic accuracy with much less distortion is achieved.

Anesthesia Supply Panel: A facilities supply panel for the anesthesiologist is located underneath the oscilloscope monitor in surgery. From here the anesthesiologist has immediate access to control mechanisms and indicator dials for regulating all gases, suction, hypothermia, stimulation and recording leads, operating table power supply, and gas sampling tubes. Special outlets provide access to infrared analyzing equipment, sampling pumps, switch valves for carbon dioxide and nitrous oxide, respirator equipment, gas mixing and monitoring equipment, and hypothermia cold and heat sources with controlling and monitoring devices.



To take this picture, the photographer placed his camera over one of the x-ray tube stands. The "X" on the chest of the man in the center is the target of the x-ray beam, adjustable to position of the patient's head when brain surgery begins.

Connections Are Color Coded

Color-coded, noninterchangeable connectors are provided for attaching to outlets on the panel and also at all piped-in sources throughout the surgical center. These give further assurance of safety and help preclude the administration of wrong agents to the patient.

Another unanticipated dividend of this project was the development by the anesthesiologist and medical engineer of the "St. Barnabas Non-Rebreathing Anesthesia Machine." This compact portable unit weighs only 28 pounds, yet it includes a controller-respirator. Some of the features incorporated in the design of this machine permit: (1) changes in the volume of flow of anesthetic agents, with no change in the proportionate mixture of gases used; (2) emergency air inlet system, and (3) fail-safety feature, cutting off all flow of anesthetic gases in the event of oxygen failure.

Electronics Laboratory: Built 3 feet, 6 inches above floor level, this room runs parallel to the special surgery

(*Continued on Page* 164)

When a physician chooses a physician, he usually looks for a competent man whom he knows personally and professionally, this survey shows — but his choice of surgeon is generally based on the man's reputation rather than personal acquaintance

How a Doctor Chooses His Doctor

Milton C. Maloney, M.D., Ray Trussell, M.D., and Jack Elinson, Ph.D.

CRITICAL examination of existing methods for measuring the quality of medical care reveals that, in the final analysis, virtually all of them rely on professional judgments for their validity. Such judgments either set standards against which the medical care facility is compared or estimate the level of performance of the medical care personnel. Although other professions are sometimes called upon, physicians generally are assumed to be the best qualified and most frequently are chosen to make these judgments and set these standards. **The study on which we are making a partial report herein accepts this assumption and further assumes that physicians will make their most critical decisions with respect to medical care when they are choosing it for themselves or members of their families.**

The basic source of data for this report is a personal interview with 468 physicians, constituting 88 per cent of a probability sample of all actively practicing doctors of medicine who were members in good standing of the Medical Society of New Jersey at the time the sample selection was made (September 1957).

This report is limited to those parts of the study which are concerned with the characteristics of the medical care actually requested and obtained by the respondent for himself or members of his family over a three-year period immediately preceding the interview. From the interviews a roster of physicians chosen to provide medical care to the respondents or members of their families was developed. Each physician on this roster was sent a

Table 1—Characteristics of the Personal Physician of Various Categories of New Jersey Physicians, by Type of Respondent, 1958 (in per cent)*

Characteristic of Personal Physician	All Respondents (N=192)	Type of Respondent†				
		General Practitioners (N=43)	Diplomated Specialists (N=70)	Non-diplomated Specialists (N=77)	Surgical Specialists (N=70)	Nonsurgical Specialists (N=79)
All personal physicians	100%	100%	100%	100%	100%	100%
Age, 50 years and over	40	51	19	49	40	31
Type of practice:						
Specialist, full-time	62	44	67	70	71	66
Specialist, not full-time	14	22	9	15	13	10
General practitioner	9	20	6	4	5	5
Information not obtained	15	14	18	11	11	18
Diplomate, American Board	52	30	70	53	57	66
Membership in professional organizations:						
AMA	92	93	88	94	94	89
FACP	41	26	48	44	44	46
Hopital staff appointment	98	95	99	96	100	99
Director of hospital department	24	28	17	27	24	20
Faculty appointment, medical school	20	17	18	26	21	23
Solo practice, fee for service	76	73	78	74	83	71
Specialty:						
Internal medicine	73	38	88	68	75	83
Surgery	14	24	3	10	15	3
Graduate, foreign medical school	4	5	3	4	6	1

* Complete distribution for each characteristic is not shown in all instances; when it is shown, percentage may not total 100 per cent because of rounding.
† Diplomate status of two respondents not recorded.

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Condensed from a paper presented to the Medical Care Section, American Public Health Association, based on an investigation supported in part by the Federal Hospital Council, U.S.P.H.S., and published initially in the American Journal of Public Health, November 1960.

Table 2 — Characteristics of Relationship Between New Jersey Physicians and Their Personal Physician, by Respondent, 1958 (in per cent)*

Characteristic of Respondent-Personal Physician Relationship	All Respondents (N=192)	Type of Respondent†				
		General Practitioners (N=43)	Diplomated Specialists (N=70)	Non-diplomated Specialists (N=77)	Surgical Specialists (N=70)	Nonsurgical Specialists (N=79)
All personal physicians	100%	100%	100%	100%	100%	100%
Resides in same county	82	78	83	84	83	85
Nature of personal relationship:						
Close personal or entertained friend	65	52	73	65	59	77
Not personally acquainted	10	15	7	9	11	5
Known by respondent 10 years or more	55	56	44	65	52	57
Nature of professional contacts:						
On same hospital staff	82	80	82	84	88	77
On hospital staff where respondent trained	17	20	10	20	12	19
Has been referred patients by respondent	82	78	81	88	83	84
Has referred patients to respondent	66	46	78	68	68	76
Estimate of competence:						
Above average	95	93	97	93	95	96
Exceptional	48	43	43	57	56	44
Reasons for selection (multiple):						
Technical competence	86	80	84	92	95	82
Personality factors	48	59	47	41	51	38
Reputation; recommendation	8	2	9	11	11	8
Professional contact or personal friendship	45	48	35	53	48	40
Rank or position	2	0	3	3	0	6
Membership in professional organizations	1	0	1	1	1	1
Estimate of professional status:						
Not a specialist	11	24	8	6	5	8
Part-time specialist	7	15	3	4	4	4
Full-time specialist	20	15	19	23	29	15
Diplomate, American Board	52	37	57	60	55	60
Teacher	10	10	13	7	7	13

*Complete distribution for each characteristic is not shown in all instances; when it is shown, percentage may not total 100 per cent because of rounding.
†Diplomate status of two respondents not recorded.

Table 3—Characteristics of the Surgeon Chosen by N. J. Physicians, by Type of Surgery and Location of Hospital Where Surgery Was Performed, 1958 (in per cent)*

Characteristic of Surgeon	All Surgery (N=244)	Major Elective Surgery		
		All (N=155)	Location of Hospital	
			In N. J. (N=105)	Out of N. J. (N=50)
All surgeons	100%	100%	100%	100%
Location of practice—not in N. J.	24	31	0	100
Graduate, foreign medical school	9	7	8	3
Method of practice:				
Salaried	5	8	2	26
Partnership	16	18	20	15
Type of practice:				
Surgical specialty, full-time	77	80	77	86
Surgical specialty, not full-time	5	5	6	1
General practice	0	0	0	0
Information not obtained	17	16	17	13
Diplomate, American Board	67	68	60	87
Membership in professional organizations:				
FACS	64	66	59	82
FACOG	9	15	12	22
AAGP	0	0	0	0
Faculty appointment, medical school	26	33	18	77
Director of hospital department	32	38	32	49
Operated in hospital with 500 or more beds	14	19	1	61

* Complete distribution for each characteristic is not shown in all instances; when it is shown, percentage may not total 100 per cent because of rounding.

mail questionnaire requesting information about certain professional and personal characteristics; 94 per cent responded. In addition, information on many of the questionnaire items was determined by reference to current, readily available biographical sources, such as the directory of the American Medical Association, the American College of Surgeons directory, and the several state medical society directories, so that in the event of nonresponse to the mail questionnaire, data were available to characterize the chosen physician. In addition to being asked the names of the physicians chosen, each respondent was asked questions concerning the episode for which the physician was chosen, his knowledge of the man's objective characteristics, the nature of the personal relationship between them, his reasons for choosing him, and an estimate of the physician's competence.

What Characterizes Choice?

What, then, are some of the characteristics of the medical care chosen by physicians for themselves and their families? First, the personal physician: When asked if everyone should have a personal physician, nine out of 10 of the respondents agreed. Seven out of 10 felt that even physicians should have a personal physician. But only two out of five, or 40 per cent of the respondents, indicated that they had someone whom they considered to be their personal physician; moreover, only one-fifth (18 per cent) of all respondents had seen their personal physician for any reason in the past year.

Table 1 summarizes the occurrence of certain characteristics among the personal physicians by type of respondent. It shows that:

1. Eight out of 10 of the men named as personal physicians are self-styled specialists. Three-fifths of them limit their practice to their specialty. One in 10 is a general practitioner.

When the doctor is a specialist, he is likely to choose his own doctor from one of the specialties

2. One-half are diplomates of an American board.

3. Four out of 10 are fellows of the American College of Physicians.

4. Virtually all of the personal physicians have hospital appointments, and one in four is the director of his department.

5. One in five is on the faculty of a medical school.

6. Four out of five are in private practice on a fee-for-service basis.

7. More than 70 per cent of the personal physicians are specialists in internal medicine.

Table 1 also shows that:

1. When a general practitioner chooses a personal physician he is less likely to choose a full-time specialist, a diplomate or a fellow of the American College of Physicians than a specialist will when he selects a personal physician.

2. Although a general practitioner is more likely to chose a general practitioner for his personal physician, he does so only one time in five.

3. When the respondent himself is a diplomated specialist, or a nonsurgical specialist, his personal physician is an internist eight or nine times out of 10 and a diplomate of an American board about seven times out of 10.

Most Are Close Friends

Table 2 shows some characteristics of the relationship existing between the respondent and his personal physician, according to the respondent.

1. Sixty-five per cent are close personal friends or have entertained each other in their homes.

2. They frequently refer patients to each other. Four out of five respondents have referred patients to their personal physician and about two-thirds have been referred patients in return.

3. The respondent thinks highly of his doctor's competence: 95 per cent consider him to be above average and one-half consider him exceptional.

4. When asked why they chose this particular physician, nearly nine out of 10 responded in terms that related to the technical competence of the man.

Half of them mentioned personality factors and another half mentioned professional contact or personal friendship. Reputation, rank or position or membership in professional organizations were referred to infrequently.

5. When asked the professional status of their personal physician, four out of five responded in terms which indicated that they thought him to be at least a full-time specialist and one-half thought him to be a full-time specialist who was a diplomate

(*Continued on Page* 160)

Table 4—Characteristics of the Relationship Between N. J. Physicians and Their Surgeons, by Type and Location of Surgery, by Respondent, 1958 (in per cent)*

Characteristic of Respondent-Surgeon Relationship	All Surgery (N=244)	Major Elective Surgery		
		All (N=155)	Location of Hospital: In N. J. (N=105)	Location of Hospital: Out of N. J. (N=50)
All surgeons	100%	100%	100%	100%
Nature of professional contacts:				
On same hospital staff	67	60	80	15
Respondent has referred patients to surgeon	69	66	74	47
Surgeon has referred patients to respondent	37	34	45	9
Surgeon on hospital staff where respondent trained	17	18	15	27
Estimate of professional status:				
Not a specialist	2	2	2	0
Part-time specialist	3	3	3	3
Full-time specialist	19	19	26	3
Diplomate, American Board	53	44	59	10
Teacher	21	31	8	82
Nature of personal relationship:				
Close or entertained friend	26	27	33	16
Not personally acquainted	25	33	23	56
Known by respondent 10 years or more	32	31	34	24
Estimate of competence:				
Above average	89	90	90	90
Exceptional	48	51	46	62
Reasons for selection (multiple):				
Technical competence	77	76	83	65
Personality factors	34	35	39	28
Reputation; recommendation	19	19	9	39
Personal friend or acquaintance	37	39	40	35
Rank or position	5	8	4	9
Membership in professional organization	1	1	1	1

* Complete distribution for each characteristic is not shown in all instances; when it is shown, percentage may not total 100 per cent because of rounding.

Table 5—Professional Status of Anesthetists Giving Anesthesia to N. J. Physicians or Members of Their Family by Type of Care Requiring Anesthesia, 1958

Professional Status of Anesthetist	All Cases		Type of Case: Surgery		Obstetrics		Accident-Injury*
	No.	%	No.	%	No.	%	No.
All anesthetists	310	100	211	100	90	100	9
Physician	262	85	188	90	67	75	7
Nurse	26	9	11	5	15	17	0
Don't know	22	6	12	5	8	8	2

* Per cent not calculated for this type.

Salary survey:

Tables on gatefold (opposite pages) give average earnings in 1960 of various groups of workers in 15 labor market areas as compiled by Bureau of Labor Statistics

IN 1956, the average supervisor of nurses in a Boston hospital made $73.50 per week; by mid-1960, she was making $97 per week. Her counterpart in Portland, Ore., did even better; her salary rose from $80.50 in 1956 to $100 per week in 1960.

These figures were reported by the U.S. Department of Labor's Bureau of Labor Statistics in its most recent studies of occupational earnings and supplementary wage benefits in 15 major metropolitan areas. Separate reports containing additional data have been issued for each of the areas.[1]

How the Survey Was Conducted

The Bureau's studies covered voluntary and proprietary hospitals and state and local government hospitals employing 100 or more workers. Data were obtained by personal visits of Bureau field economists. The surveys were conducted on a sample basis. To obtain appropriate accuracy at minimum cost, a greater proportion of large than of small hospitals was studied. In combining the data, however, all hospitals were given their appropriate weight.

The occupations selected for study are common to most hospitals within the scope of the survey. Occupational classification was based on a uniform set of job descriptions designed to take account of variations in duties that may occur among individual hospitals.[2]

Data are presented for full-time employes, *i.e.* those hired to work the regular schedule. Students were not considered as employes. All occupational information excludes not only part-time employes but members of religious orders.

Earnings data provided in these reports exclude premium pay for overtime and for work on late shifts, as well as the value of room, board or other perquisites provided in addition to cash salaries.

Supplementary benefits and practices were treated statistically on the basis that if formal provisions in a hospital were applicable to half or more of the workers in the major occupational group (*e.g.* registered professional nurses, office clerical employes, and so on) the practice or benefit was considered applicable to all such workers. Similarly, if fewer than half the workers in the group were covered, the practice or benefit was considered nonexistent for that specific group in the hospital.

Number of Workers Employed

Approximately 385,000 workers were employed by hospitals covered by the 15 area survey. Area employments ranged from more than 100,000 in New York City to between 5000 and 7000 in Atlanta, Dallas, Memphis and Portland, Ore. Chicago hospitals employed nearly 50,000 workers, and Boston, Los Angeles-Long Beach, and Philadelphia each employed between 30,000 and 40,000 workers.

State and local government hospitals accounted for nearly a third of the combined employment in the 15 areas. Individually, the proportions ranged from slightly more than two-fifths in New York City and San Francisco-Oakland to about a sixth in Philadelphia.

Full-time registered professional nurses and other professional and technical employes together accounted for about a fifth of all hospital employes in the areas studied; office clerical workers for about a tenth, and other nonprofessional employes (including maintenance, food service, and laundry) about half of the workers. Other occupational groups, such as those engaged in hospital administration, and part-time employes accounted for the remaining portion of hospital employment. ■

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[1] Copies of these reports may be obtained, as long as the supply lasts, by writing the Bureau of Labor Statistics, Washington 25, D.C., or any of its regional offices.

[2] Available upon request as long as the limited supply lasts.

Who makes how much in hosp

Table 1 — Average Straight-Time Weekly or Hourly Earnings of Men and Women in Selected Occup

Sex and Occupation	Atlanta		Baltimore		Boston		Buffalo
	June 1960	Sept. 1956	June 1960	June 1956	July 1960	Aug. 1956	June 1960
Registered professional nurses							
Women							
Directors of nursing	—	—	$125.00	—	$134.50	—	$135.50
Supervisors of nurses	$ 82.50	$ 76.50	90.00	$ 71.00	97.00	$ 73.50	97.50
Head nurses	74.50	69.00	80.50	65.00	89.50	66.00	90.00
General duty nurses	67.00	57.50	73.00	62.50	78.50	60.50	78.00
Nursing instructors	79.50	—	91.50	—	98.00	—	98.50
Other professional and technical occupations							
Men							
X-ray technicians, chief	—	—	131.50	—	109.50	—	96.50
X-ray technicians	—	—	74.00	54.50	74.50	53.50	75.00
Medical technologists	—	—	79.00	—	72.50	64.50	78.50
Physical therapists	—	—	—	—	—	—	91.00
Women							
X-ray technicians, chief	—	—	86.50	—	89.50	—	90.50
X-ray technicians	62.50	56.50	69.00	55.50	69.50	57.50	70.00
Medical technologists	74.00	66.50	77.00	64.50	72.50	57.50	82.50
Medical record librarians	—	—	89.00	69.00	92.50	—	90.00
Medical social workers	—	—	97.00	—	94.50	—	101.50
Physical therapists	—	—	84.00	—	74.50	—	81.50
Dietitians	82.50	66.50	94.50	71.50	91.00	—	90.00
Office clerical occupations							
Women							
Clerks, payroll	—	—	65.50	—	66.50	—	68.00
Stenographers, technical	69.50	—	63.50	49.00	68.00	55.00	61.50
Switchboard operators	47.50	41.50	51.50	43.50	58.00	46.00	56.00
Switchboard operator-receptionists	—	—	44.00	—	—	—	53.50
Transcribing machine operators, technical	60.50	—	59.50	—	62.50	—	59.00
Other nonprofessional occupations							
Men							
Nurse's aides	—	—	44.50	35.00	52.50	45.00	52.50
Practical nurses	—	—	—	—	62.50	—	—
Women							
Housekeepers, chief	—	—	82.50	—	88.00	—	78.50
Nurse's aides	35.00	31.00	37.50	31.00	48.00	39.50	46.00
Practical nurses	—	—	53.00	41.00	62.50	48.50	59.00
Other nonprofessional occupations							
Men							
Dishwashers, machine	$ 0.74	—	$ 0.90	$ 0.66	$ 1.21	$ 1.00	—
Electricians, maintenance	—	—	1.94	—	2.20	—	—
Engineers, stationary	—	—	1.97	—	2.00	—	$ 2.18
Kitchen helpers	0.72	—	0.90	—	1.20	—	1.19
Porters	0.77	$ 0.69	0.95	0.72	1.24	1.04	1.28
Washers, machine	0.90	—	1.25	0.98	1.44	1.35	1.66
Women							
Dishwashers, machine	—	—	—	—	1.20	—	1.11
Finishers, flatwork, machine	0.59	—	0.88	0.61	1.12	0.92	1.19
Kitchen helpers	0.60	0.54	0.84	0.61	1.16	0.92	1.11
Maids	0.57	—	0.86	0.59	1.13	0.91	1.13

[1] Regular straight-time salaries. Excludes extra pay for work on late shifts and the value of room, board or other perquisites provided in addition to cash salaries. Averages are rounded to the nearest 50 cents.

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ffalo		Chicago		Cincinnati		Cleveland	
	June 1956	July 1960	Aug. 1956	June 1960	Sept. 1956	July 1960	Nov. 1956
				Average weekly earnings[1]			
	—	$136.00	—	$ 97.00	—	$143.00	—
	$ 76.00	102.00	$ 86.50	96.50	$ 82.00	104.00	$ 84.50
	68.50	93.50	78.50	82.00	71.50	94.50	80.00
	60.00	85.00	72.00	73.50	63.00	82.00	68.00
	—	102.50	—	85.50	—	98.00	—
	—	108.50	—	—	—	115.50	—
	69.50	86.00	72.50	72.00	—	76.00	67.00
	67.50	85.50	75.00	84.50	—	81.00	74.00
	—	98.50	—	—	—	—	—
	—	103.50	—	90.50	—	—	—
	62.50	81.00	69.00	64.50	63.00	70.00	61.00
	67.00	86.50	70.50	78.50	69.50	77.50	67.00
	74.00	99.00	—	91.50	86.00	83.00	82.00
	—	107.00	—	87.50	—	105.50	—
	—	81.00	—	92.50	—	84.50	—
	63.50	98.00	—	98.00	75.00	92.00	80.00
	—	73.00	—	67.50	—	68.50	—
	52.00	80.50	65.00	69.00	57.50	72.50	63.00
	43.00	60.00	51.00	50.50	45.50	60.50	50.50
	—	—	—	—	—	—	—
	—	75.00	—	59.00	—	68.00	—
	41.00	58.50	46.50	47.00	42.50	54.50	48.50
	—	—	—	—	—	—	—
	—	97.50	—	—	—	98.50	—
	31.00	50.00	42.50	40.00	35.50	45.50	39.00
	45.50	63.00	50.00	55.50	48.50	59.00	49.50
				Average hourly earnings[2]			
	—	$ 1.13	$ 0.84	$ 1.12	$ 0.97	$ 1.23	$ 1.02
	—	2.78	—	2.27	—	2.51	—
8	—	2.72	—	2.30	—	2.52	—
9	—	1.20	—	1.05	—	1.22	—
8	$ 0.84	1.23	0.94	1.15	0.97	1.24	1.12
6	1.22	1.43	1.25	1.40	1.26	1.57	1.48
1	—	1.18	—	1.00	—	1.10	—
9	0.86	1.17	0.88	1.03	0.86	1.10	0.97
1	0.67	1.18	0.92	0.98	0.81	1.07	0.91
3	0.63	1.14	0.91	0.97	0.80	1.06	0.91

Excludes premium pay for overtime and work on week ends, holidays and late shif
as the value of room, board and other perquisites provided in addition to cash w

and Proprietary (Nongovernmental) Hospitals, 15 Labor-Market Areas, 1956-57 and 1960

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Cincinnati		Cleveland		Dallas		Los Angeles—Long Beach		Memphis		Minneapolis—St. Paul		New York City		Philadelphia	
June 1960	Sept. 1956	July 1960	Nov. 1956	June 1960	Nov. 1956	Aug. 1960	Jan. 1957	July 1960	Dec. 1956	July 1960	Mar. 1957	July 1960	Feb. 1957	July 1960	July 1956
Average weekly earnings[1]															
$ 97.00	—	$143.00	—	$126.00	—	$137.50	—	—	—	$148.50	—	$135.00	—	$125.00	—
96.50	$ 82.00	104.00	$ 84.50	92.50	$ 79.00	106.50	$ 85.50	$ 85.00	$ 74.50	104.50	$ 88.00	106.00	$ 86.00	89.00	$ 70.50
82.00	71.50	94.50	80.00	83.00	74.00	95.00	76.50	76.00	65.00	94.50	81.00	92.50	74.00	81.50	63.00
73.50	63.00	82.00	68.00	74.00	65.00	85.00	71.00	68.00	57.50	80.00	68.50	81.00	67.50	71.50	56.50
85.50	—	98.00	—	89.50	—	107.00	—	—	—	99.00	—	102.50	—	91.50	—
—	—	115.50	—	—	—	106.00	—	—	—	113.00	—	116.00	—	—	—
72.00	—	76.00	67.00	74.50	62.50	87.00	76.00	—	—	71.00	61.00	79.00	66.50	68.50	56.50
84.50	—	81.00	74.00	—	—	104.00	81.50	76.00	—	94.50	—	78.50	65.50	69.50	61.50
—	—	—	—	—	—	91.00	—	—	—	120.50	—	89.00	—	100.00	—
90.50	—	—	—	—	—	—	—	—	—	—	—	99.50	—	83.50	—
64.50	63.00	70.00	61.00	66.50	67.50	86.00	73.50	57.50	54.00	66.00	58.00	79.00	66.00	65.50	56.00
78.50	69.50	77.50	67.00	83.50	67.50	104.50	81.50	76.50	65.00	96.50	77.50	79.00	65.00	69.00	56.00
91.50	86.00	83.00	82.00	90.50	82.50	99.00	81.50	80.00	—	96.50	79.00	104.50	83.50	92.00	68.00
87.50	—	105.50	—	—	—	114.00	—	—	—	—	—	107.50	—	89.00	—
92.50	—	84.50	—	—	—	99.00	—	—	—	95.50	—	80.50	—	85.50	—
98.00	75.00	92.00	80.00	86.00	72.50	97.00	76.00	75.50	70.50	92.50	80.00	89.50	72.00	87.00	68.50
67.50	—	68.50	—	67.50	—	78.50	—	—	—	74.50	—	68.50	—	61.50	—
69.00	57.50	72.50	63.00	—	—	84.50	70.00	—	—	67.50	63.00	75.00	61.00	61.50	51.00
50.50	45.50	60.50	50.50	47.50	43.00	66.50	54.50	42.00	38.00	59.00	52.50	61.00	49.50	52.00	42.00
—	—	—	—	—	—	66.50	—	—	—	58.50	—	55.50	—	50.00	—
59.00	—	68.00	—	63.00	—	81.00	—	52.00	—	63.00	—	70.00	—	59.50	—
47.00	42.50	54.50	48.50	41.50	38.00	60.50	51.50	—	—	60.00	56.00	49.50	39.00	39.00	32.00
—	—	—	—	—	—	66.00	—	—	—	—	—	66.50	—	45.00	—
—	—	98.50	—	—	—	96.50	—	—	—	88.50	—	98.50	—	82.00	—
40.00	35.50	45.50	39.00	35.00	29.50	57.00	47.50	32.50	29.50	55.50	52.00	46.00	35.00	37.50	27.50
55.50	48.50	59.00	49.50	47.50	40.50	65.50	52.50	45.00	38.00	63.00	54.00	61.00	51.50	45.00	35.50
Average hourly earnings[2]															
$ 1.12	$ 0.97	$ 1.23	$ 1.02	$ 0.87	—	$ 1.39	$ 1.19	$ 0.63	—	—	—	$ 1.20	$ 0.84	$ 0.92	$ 0.7
2.27	—	2.51	—	1.82	—	2.95	—	—	—	—	—	2.21	—	1.93	—
2.30	—	2.52	—	1.73	—	2.55	—	2.17	—	$ 2.61	—	2.51	—	1.83	—
1.05	—	1.22	—	0.78	—	1.35	—	—	—	1.47	—	1.18	—	0.90	—
1.15	0.97	1.24	1.12	0.91	$ 0.81	1.43	1.23	0.64	$ 0.59	1.51	$ 1.42	1.19	0.86	0.95	0.6
1.40	1.26	1.57	1.48	—	—	1.63	1.45	0.95	0.81	1.76	1.63	1.47	1.11	1.22	0.9
1.00	—	1.10	—	—	—	1.32	—	—	—	1.40	—	1.14	—	0.87	—
1.03	0.86	1.10	0.97	—	—	1.31	1.12	—	—	1.44	1.36	1.19	0.87	0.97	0.6
0.98	0.81	1.07	0.91	0.68	0.55	1.27	1.06	0.48	0.45	1.41	1.32	1.11	0.85	0.88	0.6
0.97	0.80	1.06	0.91	0.75	0.63	1.30	1.10	0.48	0.40	1.41	1.32	1.17	0.85	0.92	0.6

and work on week ends, holidays and late shifts, as
other perquisites provided in addition to cash wages.

NOTE: Dashes indicate no data reported, data that do not meet publication criteria, or data unavailable at press time.

shows sharp increase in salaries of hospital
st four years. Range of increase in nurses'
ngovernmental hospitals between 1956-57
from $6 to $24.50 per week.

	Portland (Ore.)		San Francisco—Oakland	
July 1956	July 1960	July 1956	Aug. 1960	Nov. 1956
—	$137.50	—	$152.00	—
70.50	100.00	$ 80.50	110.50	$ 86.00
63.00	87.00	73.50	98.00	77.50
56.50	79.50	67.50	83.50	72.00
—	97.50	—	111.50	—
—	91.00	—	114.00	—
56.50	89.00	72.50	89.50	82.00
61.50	89.50	72.50	108.50	81.50
—	—	—	99.50	—
—	—	—	103.00	—
56.00	82.50	74.50	85.00	73.50
56.00	87.00	71.50	104.50	80.00
68.00	104.50	78.50	108.50	82.00
—	—	—	110.00	—
—	107.00	—	95.50	—
68.50	94.50	77.50	99.50	79.00
—	70.50	—	88.50	—
51.00	83.50	66.00	82.00	72.50
42.00	62.50	52.00	71.50	62.00
—	59.50	—	70.00	—
—	74.00	—	77.50	—
32.00	61.00	51.00	65.50	62.00
—	—	—	61.50	—
—	82.00	—	101.00	—
27.50	56.00	45.50	64.50	57.00
35.50	59.50	50.00	67.50	57.00
$ 0.71	$ 1.44	$ 1.25	$ 1.56	$ 1.43
—	—	—	—	—
—	2.78	—	2.67	—
—	1.44	—	1.48	—
0.68	1.48	1.27	1.57	1.44
0.98	1.78	1.53	1.71	1.49
—	1.42	—	—	—
0.60	1.36	1.16	1.52	1.40
0.67	1.35	1.16	1.51	1.31
0.61	1.36	1.11	1.56	1.34

Table 2 — Average Straight-Time Weekly or Hourly Earnings of Men and
(State, County, Municipal and Other) and Voluntary and Proprietary (No

**Earnings data for employes in these hospitals relate to cash wages and
value of room, board and other perquisites. Generally, perquisites are
free meals and uniforms (or laundering) provided to workers in such jobs**

Sex and Occupation	Atlanta	Balti-more	Boston	Buffalo	Chicago	Cincin-nati	Cleve-land	Dall
Registered professional nurses							Average weekly	
Women								
Directors of nursing	—	$131.50	$135.00	$142.00	$140.00	$118.00	$143.50	$13
Supervisors of nurses	$80.50	95.50	100.00	106.50	105.00	101.00	104.50	9
Head nurses	71.50	82.50	91.50	95.50	95.50	85.50	95.00	8
General duty nurses	65.00	74.00	79.50	80.50	85.50	77.50	82.00	7
Nursing instructors	79.50	92.00	98.50	102.00	102.00	87.00	99.50	8
Other professional and technical occupations								
Men								
X-ray technicians, chief	—	123.00	108.00	97.00	110.50	—	115.00	
X-ray technicians	67.00	75.00	76.50	83.00	85.50	79.00	74.50	7
Medical technologists	76.00	83.00	74.50	79.50	87.00	90.00	80.00	8
Physical therapists	—	—	99.00	94.00	99.00	—	—	
Women								
X-ray technicians, chief	—	86.50	92.50	96.00	101.50	90.50	—	
X-ray technicians	63.00	71.50	72.00	75.00	82.00	70.50	70.50	6
Medical technologists	74.50	79.50	73.00	84.00	87.00	81.50	77.50	8
Medical record librarians	92.50	93.50	93.00	93.50	99.50	93.50	87.50	8
Medical social workers	—	103.00	93.50	104.00	100.50	95.50	104.00	
Physical therapists	—	85.50	77.50	86.50	82.50	88.50	84.50	8
Dietitians	82.50	98.50	93.00	94.00	98.00	100.00	92.50	8
Office clerical occupations								
Women								
Clerks, payroll	—	66.00	68.00	71.00	74.50	71.50	69.00	6
Stenographers, technical	69.50	70.50	72.00	68.00	80.50	70.50	72.00	7
Switchboard operators	45.50	55.00	62.50	61.00	62.00	57.00	61.00	4
Switchboard operator-receptionists	—	49.00	62.00	58.50	73.00	48.00	56.50	
Transcribing machine operators, technical	58.50	62.50	62.50	65.00	74.00	59.00	67.00	5
Other nonprofessional occupations								
Men								
Nurse's aides	—	53.50	59.50	68.50	64.00	56.00	53.50	4
Practical nurses	—	65.00	75.50	—	—	63.00	—	4
Women								
Housekeepers, chief	—	83.00	89.50	83.50	96.00	83.50	98.00	
Nurse's aides	33.00	46.50	55.00	55.50	54.00	45.00	46.50	3
Practical nurses	42.00	60.00	68.50	62.50	66.50	61.50	60.00	4
							Average hour	
Men								
Dishwashers, machine	$0.68	$1.06	$1.43	—	$1.23	$1.14	$1.23	$
Electricians, maintenance	2.16	2.06	2.22	$2.53	3.52	2.76	2.48	
Engineers, stationary	2.27	2.04	2.16	2.31	3.27	2.50	2.52	
Kitchen helpers	0.71	1.02	1.40	1.40	1.41	1.30	1.20	
Porters	0.74	1.02	1.38	1.38	1.52	1.25	1.21	
Washers, machine	0.90	1.25	1.58	1.78	1.51	1.56	1.58	
Women								
Dishwashers, machine	—	—	1.20	1.11	1.19	1.02	1.12	
Finishers, flatwork, machine	0.60	0.88	1.36	1.33	1.27	1.21	1.12	
Kitchen helpers	0.56	0.97	1.21	1.27	1.40	1.19	1.10	
Maids	0.55	1.00	1.29	1.24	1.28	1.17	1.09	

nd Women in Selected Occupations in Nonfederal Government Nongovernmental) Hospitals, 15 Labor-Market Areas, Mid-1960

and do not include the re typically limited to obs as kitchen helpers.

Dallas	Los Angeles—Long Beach	Memphis	Minneapolis—St. Paul	New York City	Philadelphia	Portland (Ore.)	San Francisco—Oakland
veekly earnings[1]							
$133.50	$145.00	$127.00	$153.50	$138.50	$127.50	$137.50	$158.50
92.00	116.00	83.00	108.50	109.00	93.00	103.00	116.00
83.00	105.00	75.00	95.00	94.00	82.50	88.50	105.50
74.00	89.00	68.50	80.50	82.50	72.00	79.50	87.50
89.50	116.50	78.00	103.00	100.00	93.50	98.00	113.00
—	107.00	—	115.50	110.50	105.50	91.00	114.00
74.50	90.50	52.50	73.50	79.00	66.50	88.00	91.00
88.50	108.00	74.50	94.50	80.50	69.50	89.50	110.00
—	100.00	—	119.50	86.00	95.50	—	101.00
—	111.50	—	88.50	99.50	84.00	—	111.50
67.00	88.00	57.00	70.00	78.50	66.00	81.50	88.00
82.00	109.00	77.00	98.50	80.00	69.00	86.50	106.00
84.50	101.50	80.00	100.00	101.50	92.50	104.00	112.00
—	122.00	—	114.50	102.00	93.50	—	123.00
81.50	103.00	—	96.00	80.50	85.50	101.00	98.50
86.50	99.00	75.50	95.50	86.50	88.50	95.50	102.50
69.50	82.00	56.00	75.50	69.50	62.00	74.50	88.00
71.50	86.00	—	72.50	74.50	63.50	83.50	84.00
48.00	69.50	43.50	62.00	63.50	53.00	64.50	74.50
—	68.00	43.50	59.50	59.00	50.00	59.50	74.00
59.00	81.00	52.00	66.50	70.00	59.50	67.00	80.50
40.50	65.50	36.00	63.00	63.00	48.00	60.50	68.50
45.50	76.00	—	69.00	69.00	47.50	—	72.00
—	97.50	60.50	94.50	92.00	82.00	85.00	103.00
35.50	61.50	32.50	57.50	57.50	43.00	56.50	67.00
46.50	75.50	44.50	65.50	67.00	48.00	60.50	72.50
hourly earnings[2]							
$0.87	$1.53	$0.64	$1.66	$1.20	$1.01	$1.39	$1.61
1.98	3.40	2.22	3.27	2.32	1.96	2.63	3.29
1.62	2.80	2.30	2.63	2.88	1.87	2.73	2.75
0.78	1.46	0.61	1.52	1.35	0.98	1.44	1.69
0.90	1.65	0.66	1.64	1.33	1.04	1.54	1.71
1.02	1.75	.94	1.84	1.59	1.27	1.84	1.81
0.62	1.54	0.61	1.39	1.14	0.92	1.43	—
—	1.41	0.49	1.56	1.19	1.02	1.41	1.62
0.70	1.36	0.50	1.45	1.41	0.95	1.36	1.57
0.75	1.46	0.53	1.45	1.39	0.95	1.37	1.61

Notes for Tables 2 and 3

[1] Regular straight-time salaries. Excludes extra pay for work on late shifts and the value of room, board or other perquisites provided in addition to cash salaries. Averages are rounded to the nearest 50 cents.

[2] Excludes premium pay for overtime and for work on week ends, holidays and late shifts, as well as the value of room, board and other perquisites provided in addition to cash wages.

NOTE: Dashes indicate no data reported or data that do not meet publication criteria.

Tables 2 and 3

ight-time salaries. Excludes
ork on late shifts and the
board or other perquisites
ition to cash salaries. Aver-
d to the nearest 50 cents.

mium pay for overtime and
ek ends, holidays and late
the value of room, board
uisites provided in addition

indicate no data reported
not meet publication criteria.

Sex and Occupation	Baltimore	Boston	Buffalo
Registered professional nurses			
Women			
Directors of nursing	—	$137.50	—
Supervisors of nurses	$103.50	108.00	$125.50
Head nurses	86.50	95.50	104.50
General duty nurses	—	83.00	87.00
Nursing instructors	100.50	101.50	—
Other professional and technical occupations			
Men			
X-ray technicians, chief	—	—	—
X-ray technicians	79.00	79.00	90.50
Medical technologists	91.50	84.50	—
Physical therapists	—	—	—
Women			
X-ray technicians, chief	—	—	—
X-ray technicians	76.00	81.00	—
Medical technologists	84.50	76.00	86.50
Medical record librarians	102.50	94.50	—
Medical social workers	110.50	89.50	—
Physical therapists	—	82.50	—
Dietitians	109.00	100.50	104.00
Office clerical occupations			
Women			
Clerks, payroll	—	71.50	76.50
Stenographers, technical	77.00	79.00	—
Switchboard operators	65.00	72.00	73.00
Switchboard operator-receptionists	—	—	65.00
Transcribing machine operators, technical	67.50	63.00	68.50
Other nonprofessional occupations			
Men			
Nurse's aides	58.50	62.50	71.50
Practical nurses	68.50	76.00	—
Women			
Housekeeper, chief	—	93.50	—
Nursing aides	58.50	63.50	69.00
Practical nurses	65.50	76.00	75.50
Men			
Dishwashers, machine	$ 1.31	$ 1.63	—
Electricians, maintenance	2.34	2.25	$ 2.59
Engineers, stationary	2.24	2.31	2.49
Kitchen helpers	1.22	1.60	1.57
Porters	1.24	1.64	1.58
Washers, machine	—	1.78	1.94
Women			
Dishwashers, machine	—	—	—
Finishers, flatwork, machine	—	1.69	—
Kitchen helpers	1.29	1.61	1.65
Maids	—	1.65	1.55

Table 3 — Average Straight-Time Weekly or Hourly in Nonfederal Government (State, County, Municipal

Chicago	Cincinnati	Cleveland	Los Angeles—Long Beach	Memphis	Minneapolis—St. Paul	New York City	Philadelphia	Portland (Ore.)	San Francisco—Oakland
Average weekly earnings[1]									
$157.50	—	$144.50	$189.50	—	$164.00	$150.50	$145.00	—	$172.50
112.50	$106.00	106.00	135.00	—	116.00	112.00	110.50	—	123.00
99.00	94.50	96.00	124.50	$73.50	96.00	97.00	—	$98.00	114.50
88.00	83.50	82.50	102.00	—	82.50	86.50	—	81.00	94.00
—	98.00	—	—	—	111.00	97.50	—	—	—
121.50	—	—	—	—	—	96.00	—	—	—
—	—	70.50	94.50	—	—	78.50	—	—	92.00
89.00	—	—	117.50	—	—	89.50	—	—	112.50
—	—	—	114.50	—	—	84.00	—	—	103.00
—	—	—	—	—	—	—	—	—	121.50
87.00	83.00	71.50	95.50	—	81.50	77.50	—	—	91.50
89.00	92.50	77.50	116.00	79.00	103.00	89.00	—	—	108.50
103.50	—	96.00	—	—	107.00	89.00	97.00	—	123.00
—	—	101.00	125.00	—	114.50	93.00	—	—	130.00
—	83.00	84.50	110.00	—	—	81.50	—	—	104.50
98.00	—	93.50	108.00	75.00	101.50	83.00	98.50	—	109.50
81.00	—	71.50	98.50	—	78.50	—	—	—	87.50
80.50	72.50	70.50	89.50	—	78.00	—	69.50	—	87.50
74.00	69.00	63.00	81.50	—	70.00	68.50	59.50	—	79.50
68.50	—	56.50	80.50	—	—	—	—	—	—
—	—	62.50	81.00	51.00	70.00	—	58.50	—	85.00
68.50	60.00	52.00	69.50	32.50	68.50	67.50	55.50	—	70.50
—	—	—	80.50	—	69.00	—	—	—	78.50
90.50	89.00	96.50	—	—	—	86.50	—	—	—
67.00	54.50	49.50	69.00	32.50	62.00	66.50	55.50	60.00	70.00
72.00	67.50	62.50	80.50	—	70.00	72.50	—	63.00	78.50
Average hourly earnings[2]									
$ 1.67	—	—	$ 1.68	—	—	—	$ 1.33	—	$ 1.79
4.12	$ 3.15	$ 2.41	3.54	—	$ 2.91	$ 2.73	2.10	—	3.53
4.11	2.68	2.50	3.17	—	2.75	3.33	2.10	—	2.99
1.86	1.43	1.17	1.75	$ 0.62	1.56	1.57	—	—	1.78
2.12	1.43	1.15	1.97	0.68	1.79	1.57	—	—	1.83
1.90	—	1.60	1.96	—	1.94	1.85	1.65	—	2.00
—	—	1.16	1.75	0.59	—	—	—	—	—
1.66	1.55	1.21	1.60	—	1.70	—	1.31	$ 1.53	1.77
1.73	1.43	1.17	1.72	0.52	1.51	1.58	1.38	1.41	1.75
1.84	1.46	1.16	1.98	—	1.57	1.57	1.35	1.40	1.75

Earnings of Men and Women in Selected Occupations and Other) Hospitals, 13 Labor-Market areas, Mid-1960

Comparison of data in Table 3 above with 1960 figures in Table 1 (front of insert) shows that workers in most categories earn more in nonfederal governmental hospitals (state, county, city) than they do in nongovernmental (voluntary and proprietary) hospitals.

Mealtime is a happy time with a cheerful volunteer who has time to divert small patient's mind.

Registered nurse demonstrates for a volunteer the technic of placing a child in wheel chair.

Volunteer has learned to win the child's confidence as an important step in getting him to eat.

Dealing with children is a serious business to volunteers in this recreation program

Volunteers Learn How To Play With Children

Francis M. Coe

CHILDREN are not little adults and should not be treated as such, is the basic theme for training the volunteer members of the recreation department at Babies' Hospital Unit, United Hospitals of Newark, N.J.

Two years ago the 90 bed pediatric hospital launched its formal recreation program with the appointment of a full-time director of children's recreation.

Three programs were inaugurated to occupy the children's time with planned play, both at the bedside and in groups, and thus help the hospitalized children adjust to their strange environment. These programs cover outdoor and indoor group play and the bedside recreation program.

As the program began to enlarge, we asked outside groups for volunteers to participate in the activities.

A training session was held for the volunteers to acquaint them with the hospital and the recreation department. The participants and their topics are included in the outline on the opposite page.

The introductory program is further supplemented by a pamphlet of information for volunteers and by a daily orientation for the volunteer before she begins the day's activities.

This program has met with enthusiastic response and both the volunteers and patients enjoy their part in the program.

Mr. Coe is administrator of Babies' Hospital Unit, United Hospitals of Newark, N.J.

Finger games are fine fun for children who must remain in bed. This was one technic taught at the training session.

SCHEDULE FOR TRAINING PROGRAM

9 a.m.- 9:15 a.m.	Welcome to Volunteers. Francis M. Coe, administrator
9:15 a.m.- 9:30 a.m.	Volunteer-Patient Relationship. Dr. John C. Dower, director of medical education
9:30 a.m.- 9:45 a.m.	"Operation Small Fry." Dr. Richard Read, director of surgical education
9:45 a.m.-10:45 a.m.	The Art of Story-Telling and Reading Ceiling Projector Films. Introduction of Finger Games. Mrs. Elitea Allison, children's education
10:45 a.m.-11 a.m.	Coffee Break
11 a.m.-11:30 a.m.	Restrictions and Safety Hints. 1. Transportation of patients 2. Feeding of children 3. Safety devices Mrs. Anna Robinson, R.N., medical-surgical supervisor.
11:30 a.m.-11:45 a.m.	Our Play Therapy Program. 1. Functional aspects 2. Why and how to meet different needs of patients 3. Introduction of film Miss Annelies Ritter, director of children's recreation
11:45 a.m.-12:35 p.m.	Presentation of film: "A Two-Year Old Goes to the Hospital."

Emergency Care — or Lack of It — Can Make a General Hospital Liable

John F. Horty

IT IS about 11 o'clock in the evening. A man is helped, stumbling, into the emergency room of Charitable General Hospital. Outside the hospital, a lighted sign bears the words "Emergency Care Entrance." The man's hand is crushed, the result of being caught in a newspaper press. One nurse is on duty in the emergency room. The injured man is helped to a seat; the nurse asks several questions, then picks up the telephone to summon a physician.

John F. Horty

This is a routine event. Similar scenes occur daily in hospital emergency rooms throughout the country. Yet it is not hard to imagine this situation giving rise to legal problems.

Let us suppose that several facts in the opening paragraph are changed. Suppose that although the sign is lighted, "inviting" the injured man to come to the hospital for emergency care, no nurse is on duty, for the emergency room closes at 9 p.m. Or, suppose the nurse refuses to arrange for care because poor financial risks or people of certain racial origins are not treated at Charitable General Hospital. Or, suppose the nurse telephones, but is unable to locate a physician to render emergency care because the hospital has no clear-cut procedures to assure that a staff physician is available for emergency care, and the hospital has no house staff.

What liabilities could Charitable General Hospital incur? Or, to rephrase this question, in the case of a person seeking emergency care, what duty does Charitable General Hospital have which will result in liability if not performed or performed improperly?

In this and succeeding articles we will discuss the hospital's legal duty with respect to emergency care. In such a discussion, it is first necessary to determine whether a hospital has a legal duty to maintain any emergency service at all. If no such duty exists, a hospital without such service could not be liable for failure to treat a person who presents himself for emergency care.

What Is Legal Duty?

However, suppose a hospital does maintain an emergency service, what legal duties does the operation of this service entail? Must the emergency room be open and staffed at all times? Must the hospital treat all who present themselves? How competent must emergency care be, and how immediate? Finally, after emergency care is administered, what, if any, continuing duty does the hospital have toward the person treated? Upon the answer to any one of these questions may depend the outcome of a suit against the hospital stemming from an emergency situation.

Traditionally, hospitals have had no common law legal duty to maintain an emergency service or to provide emergency care to the general public. No judicial decisions have so far placed such a duty on either charitable, proprietary or governmental hospitals. Therefore, at the present time, in states where no statute or administrative regulations require that hospitals render emergency care, a failure to provide such a service would not cause a hospital to be held liable for damages to a person unable to procure emergency care.

Some State Statutes Apply

Statutes and administrative regulations dealing with emergency care do exist in some states. An *Illinois* statute, applicable to public and private hospitals alike, states that no hospital where surgical operations are performed shall refuse to give emergency medical treatment or first aid to any person who applies for the same in case of accident or injury, where refusal might cause death or severe injury. The penalty for refusal of treatment is a maximum $200 fine. However, the existence of this statute may result in a far stiffer penalty against the hospital. Noncompliance with the statute could be used as evidence by the patient in a negligence suit to show the violation of a legal duty by the hospital.

In *Pennsylvania* a statute requires all hospitals receiving payments for care of indigents to have at least one licensed physician or resident intern on call at all times. The penalty for noncompliance with the statute could presumably be loss of indigent care payments. This provision indicates that the legislature desired that medical attention always be available on short notice in such hospitals for persons who need treatment or assistance, although the statute does not specifically refer to emergency care.

A *Wisconsin* statute applicable to counties of over 250,000 population requires the establishment and maintenance, in connection with county hospitals, of an emergency unit to furnish medical care to persons in the county who have met with accident or sudden illness until such time as they may be safely moved to another hospital, or their home, or admitted to the county hospital. Or, alternatively, the board of public welfare is permitted to finance the maintenance of such a unit in a nonprofit hospital in the county.

To what extent these statutes indicate a legislative trend remains to

(*Continued on Page* 159)

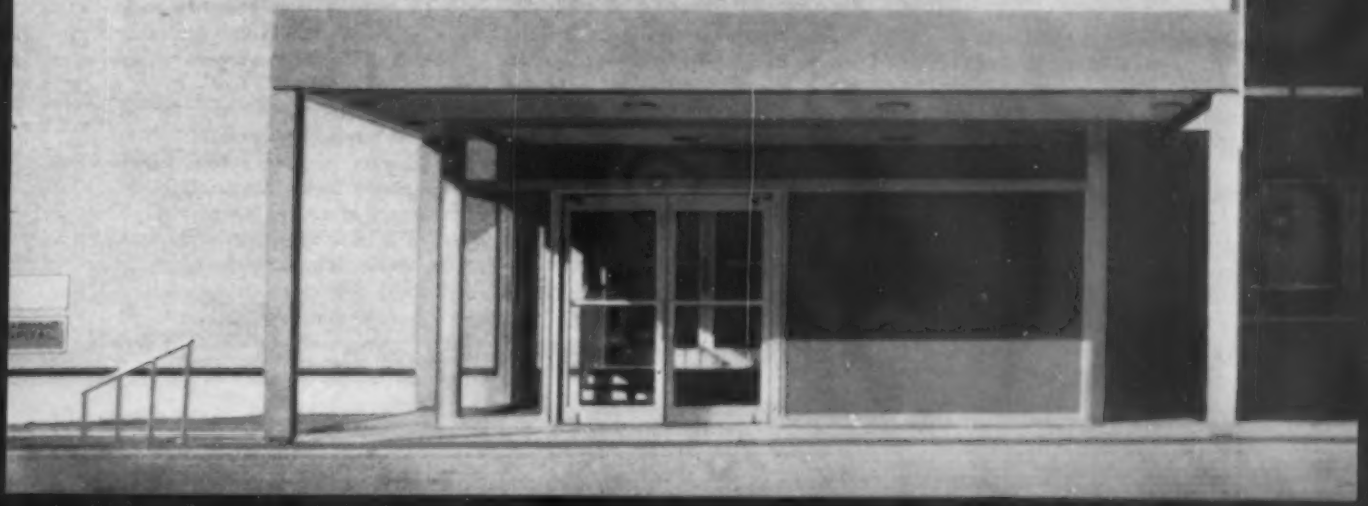
John F. Horty is director of the Health Law Center at the University of Pittsburgh. Mr. Horty's column on hospital law, a new regular feature of The Modern Hospital, started in the January issue.

The Modern Hospital of the Month

Wheels Make the Traffic Go 'Round at the New St. Barnabas Hospital

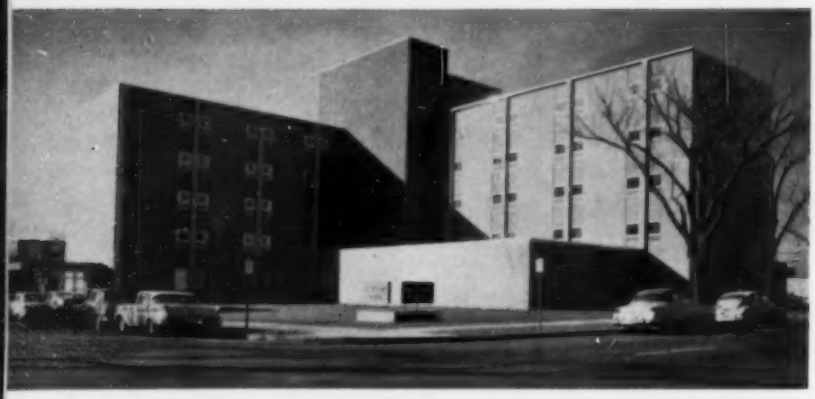
PEOPLE and supplies move with speed and dispatch in the new St. Barnabas Hospital, Minneapolis, thanks to rapid, efficient vertical transportation and to the use of wheeled equipment for horizontal movement, according to Robert W. Bachmeyer, the hospital's director.

In planning the 308 bed structure, which replaces the old St. Barnabas Hospital, hospital officials and architects strove for the most direct flow of traffic. The solution was vertical circulation in a central service core that contains passenger and (*Continued on Next Page*)



Main entrance exemplifies functional, no-frills design of the hospital.

Nursing service centers form the core of the new St. Barnabas Hospital, Minneapolis



Exterior view shows how nursing wings are offset against rectangular first floor and are intersected by the vertical service core.

freight elevators, central supply and dietary dumb-waiters, trash and linen chutes. A pneumatic tube system handles messages, records and some medicines from such strategic areas as pharmacy, laboratory, purchasing, medical records department, and the nurses' stations.

The central service core (see photograph on this page) rises from a rectangular basement and first floor in which all heavy services are grouped. The upper four floors are arranged in an offset cross pattern. This design offers several advantages from the standpoint of hospital operation, according to Mr. Bachmeyer and the architects, Magney, Setter, Leach, Lindstrom and Erickson, Inc., of Minneapolis.

Some of its major merits, from the director's point of view, are:

1. Location of service and ancillary areas in the basement and first floor reduces traffic flow and noise on the patient floors.

2. Concentration of heavy services, plus the central service department, in the basement area makes access to the upper floors easy and provides for single-flow traffic. This simplified flow of supplies is further enhanced by the separation of the elevator system, Mr. Bachmeyer points out.

3. Placing the ancillary services, *i.e.* surgery, x-ray, laboratory, physical medicine, pharmacy and administrative offices on the first floor makes it possible for outpatients and visitors to reach these areas easily and concentrates the bulk of the traffic on one floor.

4. Location of patient rooms on the second through the fifth floors — and well set back from the four street approaches — has minimized noise in these areas, as has the concentration of elevators and basic services in the central core.

5. The back-to-back arrangement of the central nursing stations permits flexibility of nursing service and provides centralization of services and supplies in a core supply area.

One Station Serves at Night

In regard to the arrangement of the nurses' stations, the architects explain that two stations are in operation during the day but only one is required at night. The stations are strategically located to control patients, guest elevator flow, supply deliveries, and dietary service. A small kitchenette is located in the nurses' control station on each floor.

One part of each nursing station, it is pointed out, is elevated so that the ward clerk has visual control of the area. Stand-up work counters allow doctors to complete medical charts or leave orders without invading the nursing station proper.

Another function that has been removed from the nursing station is the preparation of medications. The medication area is located across the corridor so that nurses who are working on medications, dosages and measurements are able to concentrate on this important phase of their work. The result, Mr Bachmeyer says, has been a marked reduction in errors in medication.

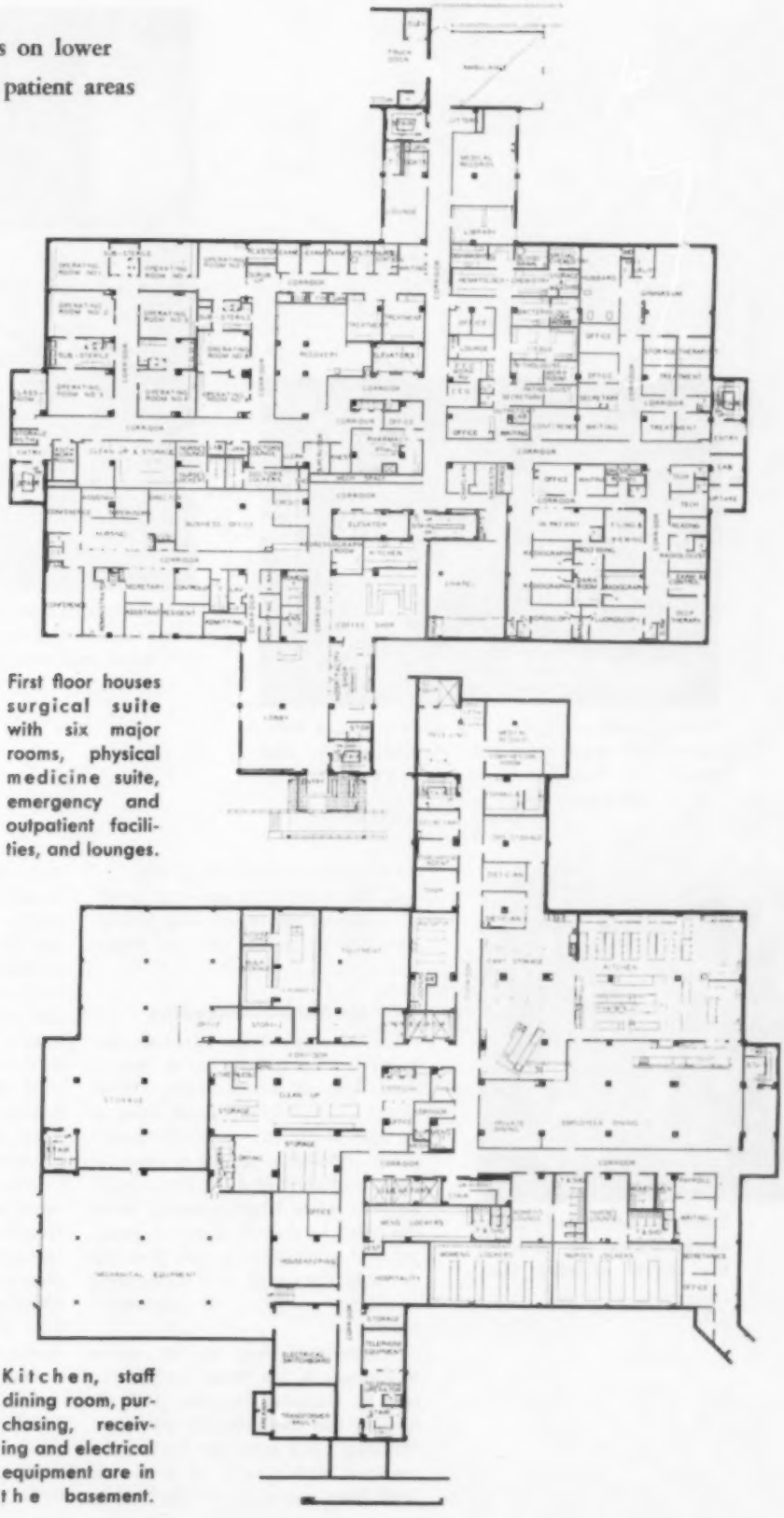
The director is also pleased with the provision of separate conference rooms for teaching and treatment rooms for patient examinations.

Waiting rooms, toilets and telephone facilities for visitors are outside the patient nursing area on each floor, a device that keeps traffic at a minimum during peak nursing activity.

Ease of maintenance and reduction of labor dictated some innovations in the setup of patients' rooms, which have proved highly satisfactory, Mr. Bachmeyer says. For example, provision of a toilet or bathroom in each room makes it possible to house all individual equipment for the patient in this area, thus freeing the bedside table for the patient's personal belong-

(*Continued on Page* 110)

Concentration of services on lower floors reduces traffic on patient areas



First floor houses surgical suite with six major rooms, physical medicine suite, emergency and outpatient facilities, and lounges.

Kitchen, staff dining room, purchasing, receiving and electrical equipment are in the basement.

Simplicity is combined with beauty in this chapel, which can accommodate 60 wheel-chair patients. The brick wall provides contrast to marble altar.

Patient rooms each have individual toilets or bathrooms with space for needed nursing supplies, thus freeing the bedside table for patient's possessions.

Communications and nursing center forms the core for the control of each floor.

(*Continued From Page* 108)

ings. The toilet room serves as a utility room for the nurses and puts all necessary equipment at their fingertips.

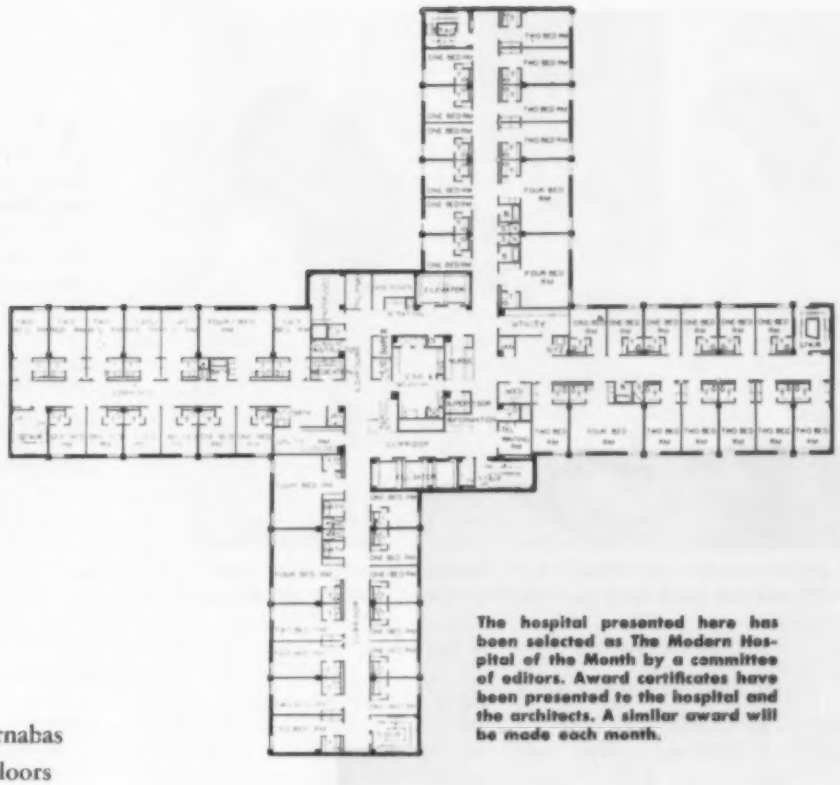
Built-Ins Aid Housekeeping

Housekeeping time has been reduced by the installation of built-in wardrobes and flower shelves. Off-set hinges on the doors permit them to be opened all the way, with consequent elimination of the scarring of both furniture and doors that usually happens when large pieces of furniture must be moved in or out. Scuffing and scarring have also been reduced by the use of vinyl wainscoting on all the corridors, Mr. Bachmeyer reports.

Wherever a wheel can be used to advantage, it has been used in the new St. Barnabas Hospital, both the director and the architects point out. Wheeled carts serve for both transportation and storage of linens. As fresh linen comes out of the laundry it is placed directly on carts and stored there until it actually goes into service. Food handling and distribution has also taken to wheels, with excellent results in terms of getting food to patients while it is still hot and palatable, and in saving employes time. Use of the wheeled carts for food distribution has obviated the need for dietary units on the patient floors, inasmuch as dumb-waiters serve the small kitchenettes located between the two nursing stations.

Wheeled equipment has proved its value in the food preparation areas, too, Mr. Bachmeyer says. The traditional walk-in coolers have been replaced by either reach-in or roll-in refrigerators and freezers, which afford greater flexibility and economy in storing cold foods than was possible under the old system. Wheeled storage units also increase the ease of handling dishes and reduce the labor involved.

While the reinforced concrete and brick building is fire-resistant, the



Patient floors provide visitors' waiting rooms, treatment and conference areas, and medication and dictation rooms separate from the nursing stations.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

Basic Design of St. Barnabas Includes Three More Floors

OUTLINE OF CONSTRUCTION COSTS

Total project cost (including Groups I and II equipment)		**$4,619,130.49**
No. of beds	**308**	
(Planned for 250 additional)		
Cost per bed		**14,997.18**
Total square feet	**174,039**	
Square feet per bed	**565**	
Cost per square foot		**22.82**
Total cubic feet	**2,236,324**	
Cubic feet per bed	**7,260**	
Cost per cubic foot		**1.78**

hospital planners decided to take no chances with the patients' safety. Maximum fire protection has been provided by the installation of a fire alarm system that is connected directly with the Minneapolis fire department. It is coded to designate all building areas, and a special coding machine is located at the main entrance where fire trucks report. This machine gives specific information as to the location of the fire so the firemen will waste no time getting to the scene.

The basic design of the building includes plans for three more floors that will increase the bed capacity to 566. Additional space for surgery, research and other needed facilities can be acquired by horizontal expansion of the building. The old hospital is being converted into research departments, resident housing, and classrooms for student nurses. The existing power plant, laundry and maintenance shops serve both the old and new buildings. ■

A patient watches admitting clerk at Memorial Hospital, Long Beach, Calif., emboss plate used for admitting and accounting procedures.

Name Plate System Strips Red Tape From Admissions

A one-step form, plus plastic convenience card, speeds up the admitting process and also serves to streamline the hospital's accounting procedure

AN ADMITTING procedure all wrapped up in red tape often delays putting the patient to bed — and infuriates him in the process.

The business office procedures at the new Memorial Hospital, Long Beach, Calif., stripped away as much of this red tape as practical to speed up the admitting process and the preliminary laboratory and placement procedures.

Focal points of the new installation are a one-step form for use by the admitting office and a "convenience" card similar to a business credit card.

Here is how the system works:

The admitting form was designed to provide three *permanent* copies — for medical records, the patient's own records, and for the doctor. The form folds back for final comments at the time the patient is to be discharged.

A duplicating machine censors information from the original admitting form according to the route the duplicate copies will travel. The duplicating machine provides part or all of the information given on the original admitting form for the medical records cross-reference file, cashier's cross-reference file, credit department, clerks who bill the insurance companies, attending physician's office records, telephone operators' directory, information clerks, public relations, chaplain's office, and medical education and the social service department.

Some forms have spaces cut out that would contain information not specifically designed for the department to which it is sent. Personal financial reports, for example, would not be available for the information clerks at the lobby desk; but the information necessary to set up the patient room register would be.

An 8 by 5 inch area across the top of the admitting form contains all of the patient information. Divided from the entire 8 by 5 inch area is key information supplied on a 5 by

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This report was prepared jointly by Ray Lake, controller, and Tom R. Gilliam, director of public relations, Memorial Hospital, Long Beach, Calif., and Charles Carner, who was on the public relations staff of the hospital at that time.

3 inch area, which is transferred to a card file. On the remaining 8 by 3 inch area is information that transfers to a ledger card and contains credit information.

The admitting office takes the information from the admitting form and makes an admitting pack that includes three statement copies and a ledger card, all on carbonless paper. This set is so constructed that only the name and address of the patient are transferred to the statement copies, although all of this information plus credit data appear on the ledger card. **In this way, all accounts receivable material is initiated as a by-product of the admitting procedure.**

The whole 8 by 5 inch form is reproduced on a duplicating machine and can be run off on 8 by 5 inch or 5 by 3 inch cards, with the admitting office disseminating the pertinent information to the departments that need it.

The second admitting office operation is the embossing of the following information on a plastic "credit" card: name, age, attending physician, hospital identification number, and room number.

Plate Goes With Patient

This plate follows the patient to his floor and is used by nurses (by means of an imprinting machine) on the floor to fill out forms ordering services and supplies. **The process eliminates almost all handwriting by nurses.**

The plate is used to imprint the plastic patient identification band, two paper inserts for reference panels in the directories of patients at each floor, and one print to be used in the telephone office directory.

The plate is also used to imprint forms used for laboratory services ordered by the patient's doctor to be performed at the time of admission to the hospital.

The preprinted form contains one copy for the laboratory, one for medical records, one for the doctor, one for the business office, and one for the patient's chart, plus a pregummed label.

The patient's embossed card goes to the patient's floor to identify him and to the nursing station for use in ordering services and supplies.

The temperature-pulse-respiration form, nurses notes, and doctors notes are all imprinted from the card. (Several imprinters are available at each nurses station.) Laboratory services from the floors are ordered on forms similar to those used for tests at the time of admission. The plastic plate also is used to imprint 8 by 5 inch double cards kept at the nurses station in a posting tray. The plate also is used to requisition services from other departments.

In the case of central sterile supply, blank charge slips are imprinted with an embossed plate to describe an item of service or supply and its price. This preprinted charge slip then accompanies the material to the nursing floor. As these items are drawn from the floor stock for use, the patient's identification is imprinted on the previously prepared slip. This three-part document is then separated. One copy is for the business office, one is returned to central supply for inventory control, and one is retained by the nursing department. These, like all charge slips, are dispatched in an electronically controlled pneumatic tube system.

The charge slip goes to the business office where ledger cards and statements are filed in an open posting tray in room number order. During the day, cashiers file the charge slips in front of the patient ledger cards. All posting is done at night. Daily hospital care charges are posted to the patient's account from the rate set forth on the index tab used to maintain the ledgers in room number order.

Posting of the charge slips is done through a coded system using the alphabet and numbers. This code system is explained on the back of each statement. Ledger card and three statement copies, one for the patient, two for insurance company, and the ledger for the hospital permanent records are all posted in the process along with the permanent ledger.

A by-product of this operation is a trial balance at the completion of the night's posting.

An unusual feature of the patient charge system is the automatic ticketing of local telephone calls. Each patient has his own telephone and may dial directly into the local exchanges. As each call is completed it is automatically registered on a meter in the cashier's area. The total of these local calls may be summarized at discharge for posting to the patient's account.

In the billing process a posting machine is used. All other accounting procedures, preparation of the payroll, payroll records and checks, accounts payable records, and general ledger accounting are accomplished on an accounting machine.

How Payroll Is Handled

Payroll is handled with completed time cards, showing total hours worked for any given employe, being delivered to the machine operator who enters the hours worked with the wage rate into the machine. Also fed into the machine is the number of dependents. Gross wages, withholding tax, F.I.C.A. taxes, net pay, and so on, are computed and printed automatically on the earning statement, check and payroll journal.

All accounting analysis of the payroll and records and a distribution of expense are accomplished as a by-product of writing the individual payroll checks on the machine.

Accounts payable records, including checks, journals and distribution, use the same equipment with similar time-saving advantages in this phase of the operation.

With all the daily accounting procedures incorporated into a single piece of equipment, the general ledger records are complete, and financial statements may be published immediately after the last monthly posting is made.

The system has been so organized that employes will soon be presented with the new embossed identification cards so that they may charge their meals in the cafeteria and in the coffee shop. ■

Rustic exterior of new Sun Valley Community Hospital fits into its ski resort setting.

Hospital Offers the Proper Setting for Skiers

This hospital looks like a resort —

and many patients come to it by accident

FROM the border of Alpine flowers around its entrance to its extensive fracture facilities, Sun Valley Community Hospital has been designed to suit the needs and the tastes of the skiing community of Sun Valley, Idaho.

The recently opened hospital, constructed at a total cost of $305,000, replaced a wing of the ski lodge which had been used for hospital service.

Emergencies total about 1500 a year, so this service is of major importance. Types of emergencies treated include fractures of the extremities, head injuries, acute coronary occlusions, cerebrovascular accidents, abdominal injuries, and pneumonia.

The hospital provides 21 beds, two obstetrical beds and two isolation rooms.

Fracture work performed in the fracture room includes manipulative treatment of closed fractures and application of casts. Open reductions and all operative procedures for treatment of fractures are performed in a special operating room.

The physical therapy department is equipped with a whirlpool bath, bicycle, two diathermy machines, and an ultrasonic machine.

If the exterior resembles a ski lodge slightly more than a hospital it is because it was planned that way. Indeed, much of the decorating was done by a local ski instructor, Florian Haemmerle, who is also an artist. So stenciled and painted designs of mountain flowers border the doors and windows.

Inside, sunny shades of pink and yellow add cheer to the patient rooms and halls. A sunburst design inlaid in the linoleum at the intersection of the two corridors carries out this theme. Pale yellow tile was used in the operating and delivery rooms, and a brownish pink in the bathrooms.

Louvered shutters have been used at the windows instead of curtains. These are designed so the lower part can be kept shut when privacy is desired but the top opened to give a view of the sky and mountains. ■

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ABOUT PEOPLE

Administrators

Dr. David A. Peters has been appointed director of Episcopal Hospital, Philadelphia. Dr. Peters is a graduate of Jefferson Medical College and received his master's degree from Columbia University School of Public Health and Administrative Medicine. He succeeds **Dr. Lucius R. Wilson,**

David A. Peters

Lucius Wilson

who becomes head of Episcopal's new development program. During the 20 years of Dr. Wilson's directorship, Episcopal attained full accreditation as a hospital and for its school of nursing, rotating internships, and residency programs. Dr. Wilson was one of the founders of the American College of Hospital Administrators.

Lt. Col. Ernest G. Rivas, MSC, has been assigned as executive officer, Fitzsimons General Hospital, Denver. A graduate of the hospital administration course conducted at Ft. Sam Houston, Tex., in conjunction with Baylor University, he has also completed the course in Hospital Administration-Federal Hospital Institute at Bethesda Naval Hospital, Bethesda, Md.

Roger Klein, former director of the graduate program in hospital administration at Emory University, has accepted the position of executive vice president of Syracuse Memorial Hospital, Syracuse, N.Y. Mr. Klein will have the dual responsibilities of administering the hospital and teaching in the medical center of New York University.

Robert E. Costello, former superintendent of Cedar Knoll School, Laurel, Md., has become director of Christ Child Hospital, Rockville, Md.

Alden A. Way has been named administrator of Cambridge Memorial Hospital, Cambridge, Neb. Previously, Mr. Way was administrator of Turtle Lake Hospital, Turtle Lake, N.D.

Patrick H. Wade has become director of the Northwestern University Medical School Clinics. Previously, he was evening administrative assistant at Chicago Wesley Memorial Hospital. Mr. Wade is a graduate of the program in hospital administration at Northwestern University. **Augustine Gunn,** assistant administrator of Presbyterian Home, Evanston, Ill., has been named to succeed Mr. Wade. Miss Gunn was formerly personnel director of Providence Memorial Hospital, El Paso, Tex. She received her master's degree in hospital administration from Northwestern University and a bachelor's degree from Howard College, Birmingham, Ala.

Dr. Allen W. Byrnes, director of professional services at the Veterans Administration hospital, St. Cloud, Minn., has been named manager of the V.A. hospital, Knoxville, Iowa. He succeeds **Dr. Albert L. Olsen,** who has been named manager of the V.A. hospital, Sheridan, Wyo.

Robert A. Paulsen, administrator of Pioneer Memorial Hospital, Prineville, Ore., has resigned to become executive director of Warrick Medical Center Hospital, Santa Rosa, Calif.

John B. Perkins has been appointed administrator of the Rehabilitation Institute of Chicago. Mr. Perkins was previously treasurer-business manager of the Christian Herald Association, Inc., New York. He attended Northwestern University and is a senior member of the American Association of Hospital Accountants. Mr. Perkins' position at the Rehabilitation Institute was created to enable the institute's director, **Dr. Bernard J. Michela,** to devote more time to medical and professional phases of the Institute, it was announced.

John B. Perkins

Charles E. Crookshanks is the new administrator of Kennedy Deaconess Hospital, Havre, Mont. Prior to accepting this position, he was a member of the administrative staff of Montana Deaconess Hospital, Great Falls.

G. Curtis Pritchard has been appointed administrator of Wills Eye Hospital, Philadelphia, succeeding **Melvin L. Sutley.** Mr. Sutley is president of the American College of Hospital Administrators and a director of the Delaware Valley Hospital Council. He will continue as a special consultant to the hospital until his retirement, which is effective April 1.

Melvin Sutley

Theodor L. Jacobsen has been named executive director of Lutheran Deaconess Hospital, Chicago. He was formerly administrator of Morton F. Plant Hospital, Clearwater, Fla. **Roger S. White,** assistant administrator for the last two years, has been selected to succeed Mr. Jacobsen.

Thomas P. Callaghan has been appointed assistant administrator, Schumpert Memorial Sanitarium, Shreveport, La. Previous to this appointment, Mr. Callaghan was an assistant administrator at St. Elizabeth's Hospital, Elizabeth, N.J. He is a graduate of the School of Public Health and Administrative Medicine, Columbia University.

Dr. Willis H. Bower has been named superintendent of Colorado State Hospital, Pueblo. He succeeds **Dr. F. H. Zimmerman,** who retired. Dr. Bower was previously assistant superintendent of McLean Hospital, Beverly, Mass.

W. H. Kelley, executive director of Blythedale Hospital, Valhalla, N.Y., has been appointed executive director of the Memorial Center for Women, Newark, N.J. **Robert Stone,** assistant director at Griffin Hospital, Derby, Conn., will succeed Mr. Kelley at Blythedale.

Gerald Bishop has accepted the position of assistant administrator, Carraway Methodist Hospital, Birmingham, Ala.

James G. Williams is the new administrator of Glynn-Brunswick Memorial Hospital, Brunswick, Ga. Previously, he was administrator of Tift County Hospital, Tifton, Ga.

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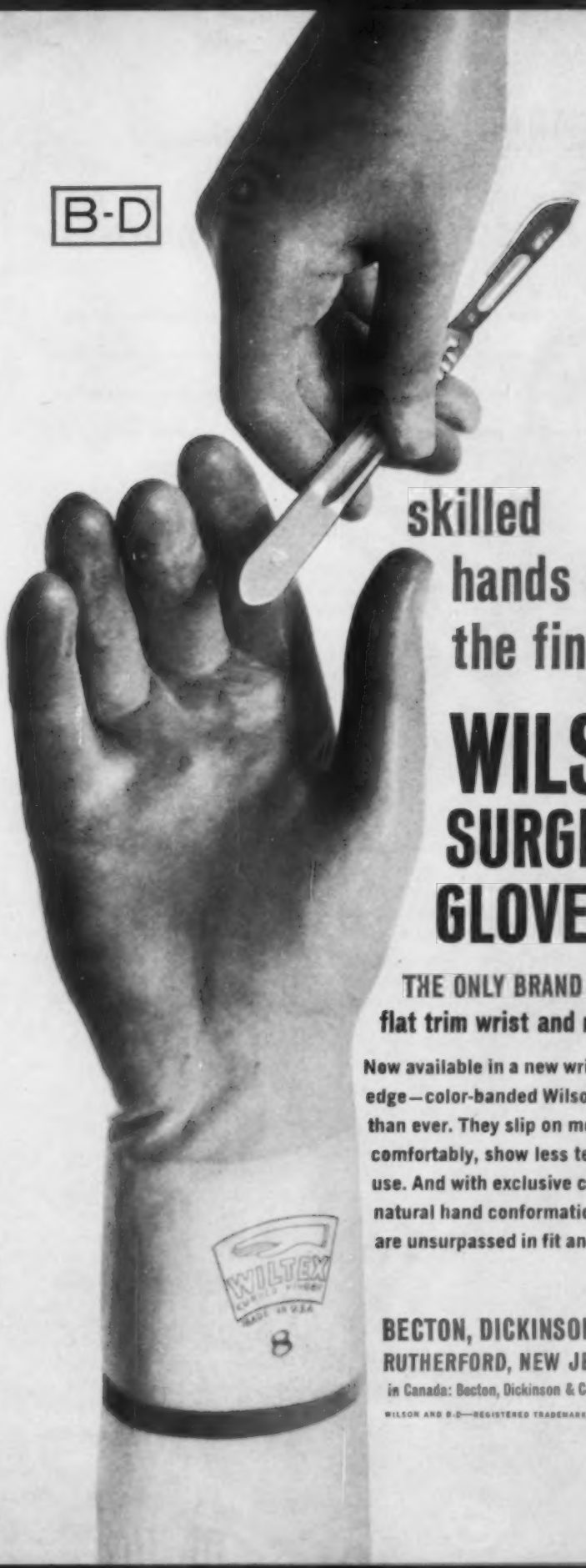

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What the Law Prescribes for Pharmacists

One thing the law prescribes is that a pharmacist shall exercise due caution, while due caution dictates that he should be acquainted with state laws that affect hospital pharmacy, as well as with accreditation standards

Emmett R. Johnson

A RECENT newspaper headline read: "Label Error Blamed in Deaths of 69 Tots." A pharmacist testified today that a labeling error was responsible for the arsenic deaths of 69 babies who were dusted with baby powder made by his firm. Parents charged that their children died "as if dipped in boiling oil."[1]

In a Connecticut case a maternity patient was negligently massaged with carbolic acid by a student nurse, producing painful burns. The carbolic acid, which was kept in the same kind of container and in the same medicine closet as rubbing alcohol, was artificially colored the same rose shade as the alcohol, in accordance with the rule of the pharmacy department. The court ruled, "This practice was dangerous and negligent."[2]

What is the law? Why are we concerned?

The two basic divisions of the law are the common law, referred to as the "unwritten" law; and the "written" or statute law, which is the creation of the legislatures. The term "common law" is used to refer to the rules which originated in court decisions as distinguished from those which originated with legislative bodies. Our common law is based on immemorial customs developed by English courts beginning in the Thirteenth Century and brought to this country by colonists.[3]

Thus, law consists of three bodies of fact and information: (1) statutes of the legislature; (2) court interpretations of what the statutes mean, and (3) case law, or court interpretations on questions not covered by either of the previous items.

Stare Decisis (let it stand as decided) is the term expressing the rule that a judicial precedent must be followed as a guide for deciding future cases. Such precedents become binding upon the courts as a rule of action in like cases. Changed social or economic conditions, however, may cause a time-honored precedent to give way to a new and different rule.[4]

The tendency has slowly manifested itself for states to enact identical statutes on commercial subjects. These efforts have resulted in the adoption in a number of states of uniform statutes, as, for example, the uniform Narcotics Act.[5]

Every hospital pharmacist should be well acquainted with his state's hospital licensing act, pharmacy act, uniform narcotic drug law, and the barbiturate law. In addition, he should be familiar with the standards of the Joint Commission on Accreditation of Hospitals dealing with the pharmacy, and with other statements of generally accepted principles of hospital pharmacy, such as those outlined by the American Society of Hospital Pharmacists.

A typical state licensing law includes only three statements about the hospital pharmacy or drug room:

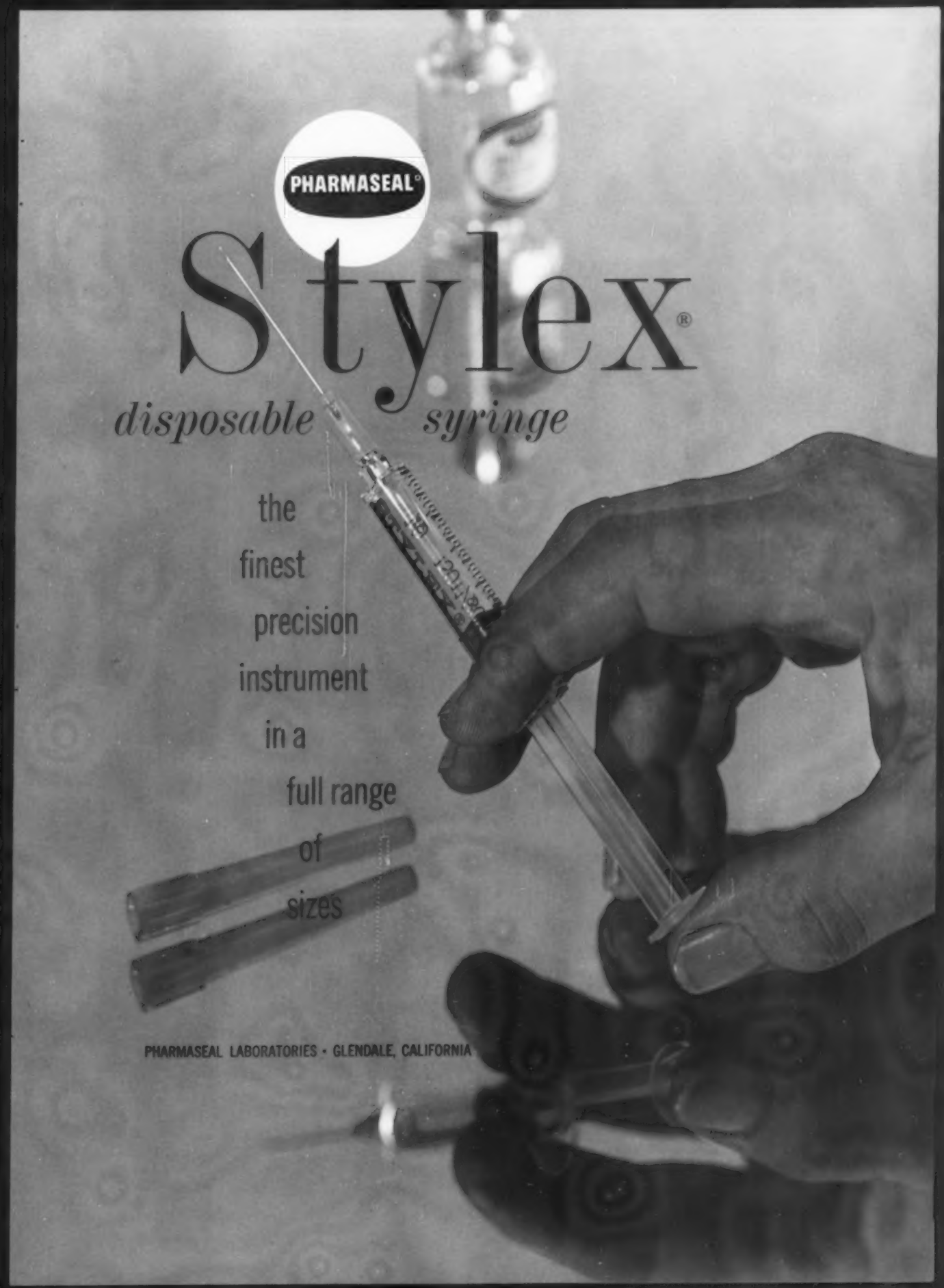
1. "There shall be a pharmacy directed by a registered pharmacist or drug room under competent supervision.
2. "Facilities shall be provided for the storage, safeguarding, preparation, and dispensing of drugs.
3. "Such special records shall be kept as are required by law."[6]

These statements imply many things, but something more should be said about the retention of records. Narcotic and barbiturate laws require those prescriptions to be retained only two years. It is difficult for the phar-

(*Continued on Page* 121)

Condensed from a paper presented at the Southeastern Conference of Hospital Pharmacists, Miami Beach, Fla., May 1960.

Emmett R. Johnson is assistant administrator of Baptist Memorial Hospital, Jacksonville, Fla. From 1952 to 1958 he was administrator of Western Baptist Hospital, Paducah, Ky. A graduate of North Texas State College, Mr. Johnson received a master's degree in hospital administration from Northwestern University. He is a past secretary-treasurer of the Southwide Baptist Hospital Association and was vice president of the area hospital council last year. He is a member of the A.C.H.A.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(*Continued From Page* 118)
macist to decide how long the original prescription should be retained. Some protection is given the pharmacist at this point by the patient's record. Various states' statutes of limitations prescribe various lengths of time during which an injured person may initiate a claim to recover damages. It should be remembered, however, that the time lapse begins at the time discovery of the injury is made; or, in the case of a minor, when adulthood is attained. In Florida, for instance, in a personal injury case involving a 10 year-old child, the statute of limitations will not have elapsed until three years following the child's attainment of age 21.

Don't Count on Immunity

The fact that a hospital is a nonprofit, charitable institution may not exempt it or the pharmacist from liability for injury to patients caused by negligence. There was a time when charitable institutions were immune from liability for injuries sustained by patients or visitors in the hospital or on its grounds. Some states still hold strictly to the charitable trust doctrine, but there appears to be a definite trend away from the theory that a charitable hospital cannot be held liable for injuries to its patients caused by the negligence of its employes. In many states today, all types of hospitals are placed on the same basis in the sight of the law as far as liability is concerned. It makes no difference whether the hospital is a charitable institution, private-not-for-profit, private-for-profit, governmental or other.

Since the charitable immunity doctrine does not protect hospitals and their professional employes in most states today, and because there is a trend in most jurisdictions toward this position, it is important that we note some basic facts concerning how pharmacists may be held liable for injuries to patients.

Hospitals are responsible for the negligent acts of professional persons by reason of contract with the patient, and by reason of tort. Contract simply means that the hospital (or pharmacist) puts itself out to give average hospital (or pharmaceutical) care and enters into a contract with any patient who places himself in the care of the hospital (or pharmacist). If it can be shown by the patient that this contract was broken, he will have cause for action and judgment against the hospital (or pharmacist). Tort simply means an injury or wrong committed with or without force to the person or property of another. Claims against hospitals and hospital employes arise, and are justified, when it can be shown that the hospital or hospital employe has been negligent.

In establishing negligence in a tort case, three elements must be proved:

1. A legal duty to exercise care.
2. Evidence that this duty has not been exercised.
3. Injury resulting from the nonexercise of this duty.

For example, "in drug compounding, a lack of exercise of legal duty to exercise care would be: improper formulation, inadequte testing and inspection of raw materials, failure to warn by label against improper use of known dangerous properties, and carelessness in compounding or bulk compounding resulting in an unsatisfactory, harmful or filthy product being released to the public."[7] It should be noted that a real injury must result.

In claims resulting from an alleged breach of contract with the patient, the legal doctrine, *res ipsa loquitur* (meaning "the thing speaks for itself"), is most often applied. The classical example of the application of this principle in hospitals is the hot water bottle burn while the patient is still unconscious following surgery. The patient went to surgery with feet which were normal; following surgery they were burned. The thing speaks for itself. If a person takes a pharmaceutical dispensed by the pharmacist, drops dead, and it is later learned that the pharmacist's negligence was involved, the informed attorney will in all likelihood apply the doctrine of *res ipsa loquitur,* putting the burden of proof on the pharmacist. Some hospitals, however, are held responsible for the acts of their employes, including pharmacists, under the legal doctrine of *respondeat superior, i.e.* the master is responsible for the acts of his agent or servant.

Recently a physician injected sparine hydrochloride. There was an unfortunate reaction to the medication. Amputation of the patient's arm finally resulted. The injection occurred in a hospital using medication issued by the hospital's pharmacist. The hospital administrator and the hospital pharmacist, among others, were subpoenaed to appear as witnesses at deposition.

The subpoena is a process to compel the attendance of a person in court as a witness. The *subpoena duces tecum* is a subpoena ordering the witness to bring with him books, documents and other evidence described in the writ. In this case, the administrator and pharmacist both received a *subpoena duces tecum*.

Entitled to Travel Fees

An attorney may issue a subpoena, signing it himself and attesting it in the name of a judge of the court, the clerk or other proper officer.[8] When and if the hospital pharmacist receives a subpoena, he should immediately notify the administrator or other administrative officer. Malpractice suits are becoming more and more a thing to be reckoned with, and the appearance at court of key hospital employes is an expensive proposition. In order to recover such expense for the hospital, it is necessary that at the time of the service of the subpoena the fees to which the witness is entitled for travel to and from the place to which he has been commanded to appear, and for one day's appearance, be tendered or paid to him. Persons who fail to appear may be held in contempt of court and accordingly punished.

The subpoena of the pharmacist in the instance mentioned was for a "deposition." The deposition is merely an affidavit, or an oath, or the written testimony of a witness in response to interrogations. The deposition is a convenience to the litigants, their counsel, and the court, because it makes possible collection of testimony under oath in an examination before trial. The *subpoena duces tecum* received by the pharmacist ordered him to bring with him "all purchase orders, invoices, billing orders, records, reports, notes of any kind whatsoever in regard to the order or purchase of the drug, sparine hydrochloride . . . covering the period from January 1, 1957 to August 21, 1957, and the vial, bottle or container used for purposes of injection into the body of one ..... on or about August 21, 1957, at a time when the

said ..... was an inpatient at the hospital." The hospital had not been named a defendant in this particular suit. Legal counsel for the plaintiff patient, for the defendants, a physician, and the pharmaceutical manufacturer, as well as the counsel for the hospital, were in attendance at the deposition. As a deposition may assist in determining all the facts surrounding a case, it many times can be used to ascertain whether additional defendants should be named. The depositions of the subject pharmacist and administrator leave the impression that plaintiff's counsel was trying to justify later naming the hospital, in addition to the physician and the manufacturer of the drug, as a defendant in the case.

Kind of Questions Asked

It may be instructive in this case to review some of the questioning.

First, both the phamacist and the administrator were questioned as to their names, their positions, occupations, qualifications for their jobs, and, in the instance of the pharmacist, a detailed description of the operation of the hospital pharmacy, including how drugs were purchased, received, stored, labeled and dispensed, transported to the floor, stored on the floor, and other administrative considerations.

On instructions from the administration, the pharmacist challenged and requested the plaintiff's attorney to accept photostatic copies of records at the plaintiff's expense. This was permitted. The hospital retained the originals, made photostatic copies, and submitted charges to the various attorneys who wanted copies.

In the 52 page deposition given by the pharmacist, the plaintiff's attorney attempted to determine the manufacturer's lot control number of the medication dispensed two years previously. Everything conceivable was asked in order to determine this fact. **Here, for example, are some of the questions:**

Q. "Where the particular injection is not requisitioned but used from floor stock, how does the business office know there is a charge to be made?"

Q. "Suppose the doctor used one cc. out of the vial, would the remaining cc. be thrown away or would it be used for another patient?"

Q. "Would you be able, when you go back, among these other little chores that we have suggested, to make a specific inquiry to ascertain if you can find that bottle or the package that it came in or anything of the kind? Would you do that?"

In the following line of questions, the attorney may have been trying to determine if the hospital pharmacist could be responsible for the injury by allowing drugs to deteriorate through poor stock rotation.

Q. "Do you have any system whereby you can assure yourself of a rotation of drugs by this – let me give you an illustration, you say you always keep on hand a certain quantity of 2 cc. vials and when you get down to that quantity you reorder. Now, do you stack a new order right on top of the old so that. . . ."

A. "No, no. As trained pharmacists, we are taught to put the older stock on the front."

Q. "So that you have a system of rotation?"

A. "Stock rotation, that's right."

Q. "Do you know whether the same system is followed up on the floor at the floor stock, whether they rotate?"

A. "For the most part, I believe it is done."

The Jury May Be Impressed

The administrator had been subpoenaed to bring with him copies of the standards of the Joint Commission on Accreditation of Hospitals. One such standard in the pharmacy section reads: "Drugs dispensed shall meet the standards established by the United States Pharmacopeia, National Formulary, New and Non-Official Drugs, British Pharmacopeia, or Canadian Formulary." The plaintiff's attorney tried to show that sparine hydrochloride was not listed in any of these publications at the time it was administered to the patient. He was eager to find facts upon which to name the hospital as a defendant. Careful analysis of the minimum standard shows it does not say the drug shall be listed in these publications, but it shall meet the standards established by these publications. However, such a line of questioning may be quite impressive to a jury. The hospital and the pharmacist would have to depend on their counsel to convince the jury that only safe practices are used in their pharmacy.

One should always be careful to state only facts, and not opinions, when acting as a witness. This is a good rule to follow in the daily course of business, too.

The pharmacist should not, under any circumstances, substitute one article for another in a prescription without the consent of the physician. No change should be made except as is essentially warranted by correct pharmaceutical procedure.

Since a patient ordinarily has no definite knowledge of the numerous medicines and poisons, he must rely implicitly on the pharmacist who holds himself out as having peculiar knowledge and skill. It follows therefore that the pharmacist warrants that he will deliver the drugs called for, and that the doctrine of *caveat emptor* (let the buyer beware) cannot apply. One state pharmacy act has this to say about substitution:

"(1) The Board of Pharmacy may revoke or suspend the license and registration certificate of any registered pharmacist, after giving such pharmacist reasonable notice and an opportunity to be heard, who shall have . . . used in the compounding of a prescription, or furnished upon prescription an ingredient or article different in any manner from the ingredient or article prescribed."

Pharmacy acts of most other states prohibit drug substitution.

Formulary System Questioned

There has been some litigation already affecting the legality of hospital formularies. A decision in Michigan has held that under the Michigan pharmacy laws it is not substitution if the exact drug is provided, even though the name is different. In that particular case a retail pharmacist provided a different brand of a generic name drug, but this was done pursuant to a prior oral agreement between the pharmacist and the prescribing physician. The court held that inasmuch as the drug provided tested exactly as the one prescribed, there was no substitution within the interpretation of the pertinent state law.

A similar case occurred in Pennsylvania. There, pursuant to the hospital formulary system which every member of the hospital medical staff

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agreed to abide by when he accepted his annual staff appointment, different brands of the same generic name drug were provided in two instances. The state pharmacy board suspended the responsible hospital pharmacist.

In Texas, a new pharmacy law prohibits substitution without approval of the prescribing physician. However, the attorney for the Texas Hospital Association has advised both the state medical and hospital associations he believes the proper operation of the hospital formulary system will be no violation of the substitution provision in the Texas act. He has recommended that to protect the pharmacist under the law, order forms or prescriptions used in the hospital ought to have the fact that the attending physician is consenting to the substitution, as allowed under the hospital formulary system, stamped or printed on the prescription. He then recommends that, in addition, "the hospital pharmacist should specify on the order or prescription the drug or brand of drug that is used in filling such prescription if this is not already being practiced." Hospital pharmacists in all jurisdictions would do well to follow the advice of the Texas attorney.

Responsible for Liquor Control

Alcoholic Liquors, Narcotics and Barbiturates. The recently confirmed liability of the hospital for retailers' alcoholic tax is an important responsibility for the hospital pharmacist. In May 1958 the Internal Revenue Service issued a special memo to all hospitals and similar institutions stating that the government has interpreted dispensing of alcoholic liquor to be the same as selling it at retail, and that hospitals are required, therefore, to purchase special occupational tax stamps costing $50 per year. The purpose of the tax stamp is to control traffic in alcohol. "Both hospital and hospital pharmacy association officials have concurred in the need for control but have flinched at the cost, pointing out that it should be similar to the $3 per annum as required by the Harrison Narcotic Act. Should all hospitals purchase the $50 tax stamp, the hospital health bill in the nation would rise another $350,000."[9] Prepackaging liquor to individual patient prescription or nursing station unit size, while it may be economically sound in lowering medication costs, is prohibited by law. Hospitals under present regulations can use only original bottles, federal stamp intact, in delivering the medication to nursing stations for individual patient use.

How To Control Narcotics

Hospital pharmacists should take the responsibility and challenge that exists in making certain that all narcotic and barbiturate drugs daily are under rigid inventory control, including nursing units as well as the pharmacy. One writer has suggested that the nursing unit should undergo a special narcotics check jointly by a nurse and pharmacist once a week. Any apparent discrepancies would be reported to both the delegated person in nursing administration and the chief pharmacist. Further, whenever possible it is a wise policy to have the issuance of narcotics assigned to one pharmacist. Then if a question arises there can be only one person responsible and no time is lost ironing out an error or misunderstanding. One pharmacist has devised Narcotic and Barbiturate Order and Audit Record Forms which are simple but all-inclusive, giving a written record of individual dosages and starting and ending inventories of each drug on each shift and nursing unit.

The inquest into two deaths in Massachusetts recently produced this statement by the judge:

"Suffice to say, however, a study of the evidence reveals acts of carelessness, carefree abandonment of responsibilities, the delegation of responsibilities to others, certain omissions to act, and wanton and reckless acts, as well as incompetence and the failure to qualify for the jobs they were intended to do on the part of the director of the ..... hospital, the chief pharmacist of the ..... hospital and the pharmacist's helper so as to warrant and justify criminal negligence on the part of the above named and described individuals, and by reason thereof, that is the finding of the court."[10]

The aforementioned tragedy occurred when a pharmacist's helper dispensed sodium nitrate solution removed from a container labeled "Phospho Soda."[10]

As far as registered nurses are concerned with the practice of pharmacy, they, too, are "nonprofessionals." Pharmacy coverage after normal pharmacy hours thus becomes a real legal problem. It is the responsibility of the hospital pharmacist to establish and operate an adequate system for protection of patients. "The least desirable system is to have student pharmacists or pharmacy technicians covering the pharmacy without supervision after hours. Probably the best method is to make a cabinet available on the ward and containing a group of drugs selected by the medical staff through the pharmacy committee. Coupled with this would be the placing of the pharmacy staff on an on-call basis. If the medical and nursing staffs use good judgment and do not place unnecessary calls this method will not place an undue burden upon the pharmacist."[11]

Must Check Every Step

Prepackaging; Preprinted Labels. Prepackaging and preprinting allow a smoother work flow in the pharmacy, reduce pressures and chance of error. A pharmacy helper under the supervision of a pharmacist can prepackage if the operation is under strict written control. The thing to remember is that the supervising pharmacist must check and document each step in the operation, and then save the documents.

Whenever possible it is preferable to use preprinted labels, because written or typed labels are liable to error in spelling and content. Naturally, all labels must be checked along with contents at the time of dispensing. ■

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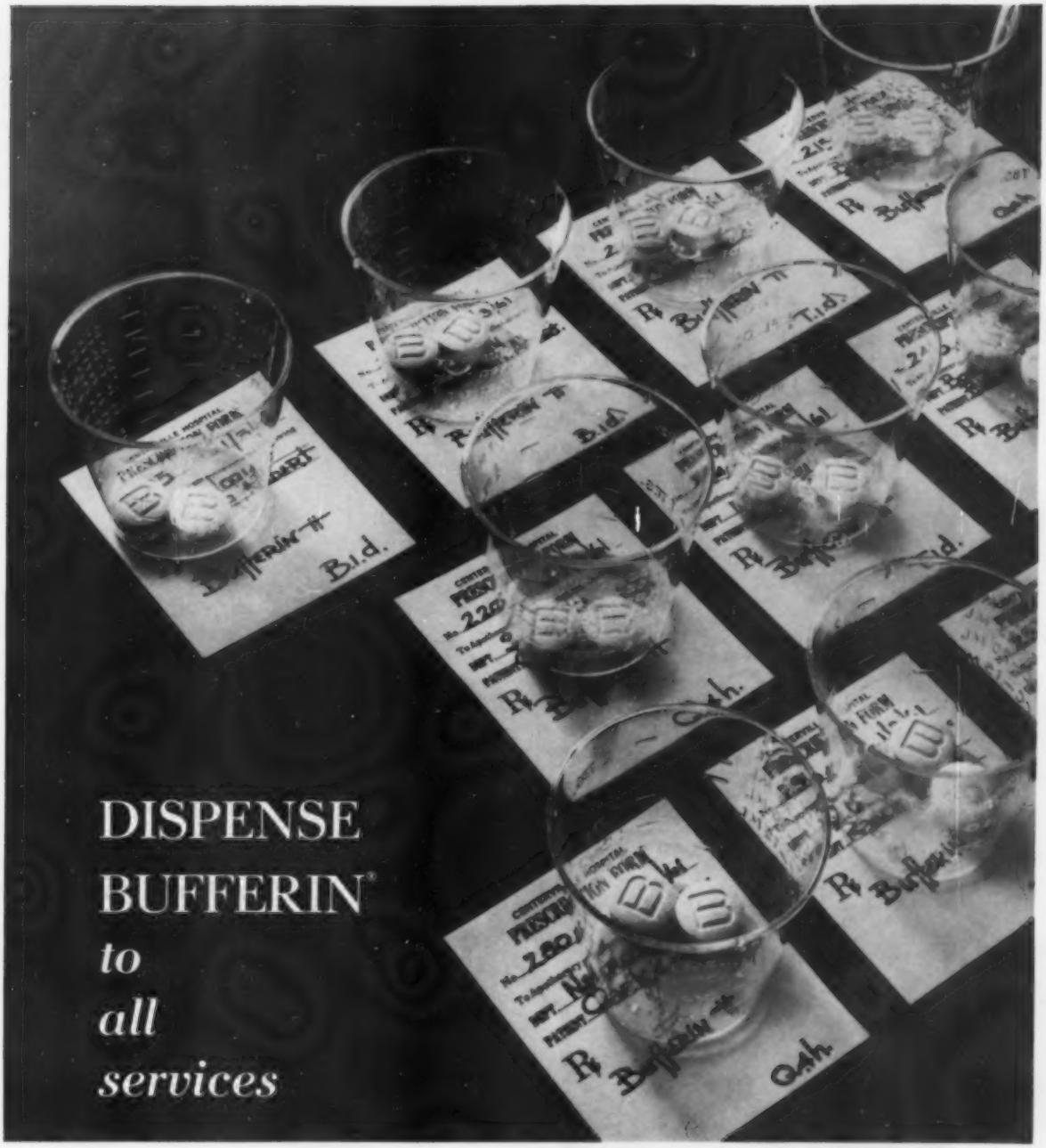

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History and Physical Examination Record Should Be Clear, Concise

By Robert S. Myers, M.D.

THE composition of an adequate history and physical examination should follow the same precise principles that govern the construction of a report made by a competent crime investigator. That is, the clues should be followed to their end by careful, exhaustive investigation, and the essential facts should be recorded in a concise, progressive, integrated manner. The result should be the same in both instances — the reader of the medical record or of the crime report should have a clear understanding of the problem by the time he reaches the end of the presentation.

Dr. Robert S. Myers

To accomplish this desirable objective in a medical record, several essentials must be observed. In the first place, the history and physical should be condensed into the smallest possible space, consistent with the presentation of all essential details of the illness. Second, the facts should be developed progressively, so that one follows another logically, integrating the details and facilitating an accurate diagnosis. Last of all, the nonessentials should be omitted, so as not to clutter the record and not to confuse those who write it and those who read it.

This does not mean, of course, that the attempt to be concise should encourage neglect of a thorough interrogation of the patient. Certainly, all essential questions about the present illness, the family and past history, and the system-symptoms should be asked; and for this purpose, the detailed outline taught to medical students is helpful, in that its use will ensure a complete interrogation done in an orderly manner.

But there is no valid reason to record all of the negatives in the written history. This does not benefit the student, for the value to him lies in the asking, not in the recording; and, as a matter of fact, the inclusion of trivia in the record dulls the ability of the physician to discriminate and to produce an intelligent record. It also wastes much valuable time and energy that could better be spent in taking care of the patient.

Nor does the omission of insignificant, negative findings cast doubt upon the validity of the written record. This is determined by the integrity of the physician making the record. A three-page history and physical examination, which includes all the negative findings, can be more spurious than a one-page record containing none. It all depends upon the thoroughness and honesty with which the record is prepared.

Actually, no one can dispute the principle that a complete history should be taken and that a complete physical examination should be done on every patient admitted to the hospital. Where disagreement does logically arise is in the recording of the findings, and this has caused the development of many different forms designed to facilitate writing the medical record. These have varied from

the check list with no written exposition to the record done entirely in writing and to all sorts of combinations in between. While it is certain that no one form is suitable for the written records of all patients and that there must be variations in forms to fit the needs of patients with different disease conditions, more thought could be given profitably to the general use of anatomical figures and diagrams, which have been devised by certain of the surgical specialties for the visual presentation of essential physical findings. The use of these, plus a brief written summary of the details of the illness, enhances the brevity, the clarity, and the completeness of the written record.

While it is too much to hope that medical records generally will ever rival detective stories in the logical presentation of essential data, it certainly is possible eventually to improve the quality of records by educating our future physicians about their proper construction. In particular, they should be taught to omit trivia and to shun the potpourri that includes everything that ever happened to the patient, regardless of its bearing upon the present illness. Otherwise, medical records resemble fish, in that size and weight determine excellence. ■

Medical Record Schools Can Handle More Students, A.M.A. Report Indicates

CHICAGO. — Medical record schools can accommodate more students than are enrolling, according to figures compiled by the American Medical Association.

Although the 29 approved M.R.L. schools have a training capacity of 253 students, only 160 students were enrolled in the schools in 1959. This, however, was a 6.5 per cent increase over the 1958 enrollment, the A.M.A. report indicated.

The report also disclosed that nearly twice as many students graduated from certificate programs as from degree programs in 1959. Out of a total of 143 graduates, 49 were from degree programs and 94 were from the one-year certificate programs, which require for entrance at least two years of college or a degree as a registered nurse.

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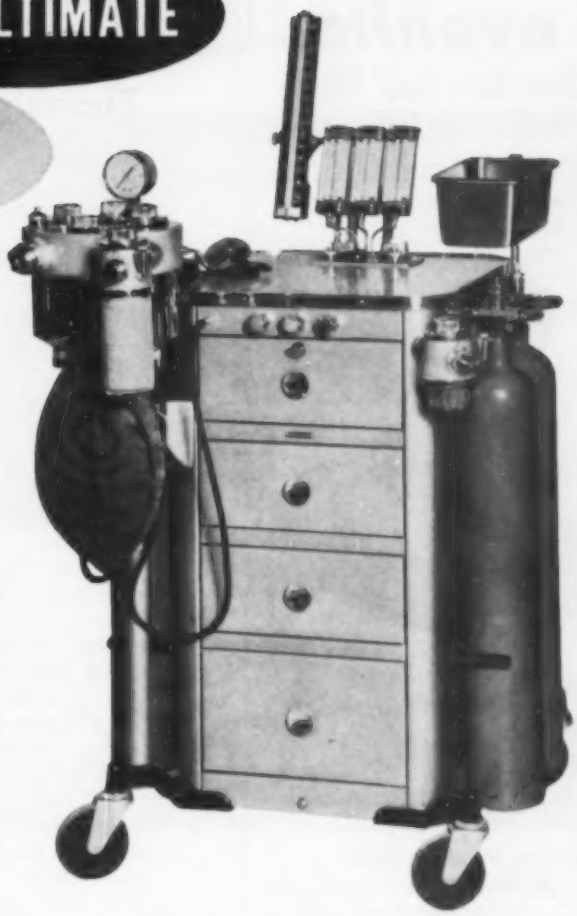

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Cystoscopic Instruments Require Thorough Disinfection Technics

By Frances Ginsberg, R.N.

ONE AREA of aseptic technic not often considered is that of instruments used for cystoscopic examinations. Yet, cystoscopic instruments have been shown to be a source of infection because of a lack of proper disinfection procedures.

Frances Ginsberg

Currently, the most widely used technic employs the formaldehyde cabinet. This is effective only if the cabinet is provided with a means to evacuate the air and can maintain an 80 per cent or higher relative humidity during the overnight period of exposure. However, when these two requisites cannot be met, other suitable and effective means must be utilized to escape the ever present danger of contamination of delicate tissue.

Since cystoscopes and other lens carrying instruments are precision made and are composed of many separate pieces, they require not only meticulous handling but also thoroughly effective disinfection procedures. Therefore, only a system that can effectively destroy all pathogens without injuring the instruments must be used.

In my opinion, the most effective way for sterilizing cystoscopes is by using an ethylene oxide gas sterilizer. Several authorities agree that in lieu of this the best alternative is an aqueous formalin solution in a two basin technic. This technic involves placing cleaned instruments in a basin, which is then covered. If a 4 per cent solution of formalin is used, a 10 minute period of submersion is required. If a 10 per cent concentration is used, a 5 minute period of submersion will achieve broad bactericidal results. The instruments should be removed with sterile gloved hands and transferred to a fresh solution of sterile distilled water where the formalin can be removed by rinsing. They can then be placed on a sterile table and used immediately.

Ureteral catheters that can be autoclaved for use during these procedures are available today. As I have often said, all items that can be autoclaved should be autoclaved. I note this because, although ethylene oxide may be used as effectively, autoclaving is still the most readily available means and the most efficient way to assure sterility.

With the stylets intact, the lumens of the catheters should be moistened to assure steam circulation within the catheters. Pairs of catheters can be threaded on catheter sterilizing papers and then enveloped in either cellophane or nylon tubing. Loaded in the upper third of the sterilizer, they may be sterilized along with other items.

This subject was brought to my attention by several urologists who were deeply concerned by the lack of aseptic technics in this field.

"The apparent lack of concern by some for the vulnerability of the genito-urinary system to infection," they said, "causes us a great deal of concern and should indeed cause others an equal amount of concern." ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

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P & T Committee Has Many Functions

Emergency drugs, stop orders, abbreviations, samples, restrictions are among concerns of this committee

by Grover C. Bowles Jr.

WHAT are the functions of the pharmacy and therapeutics committee in a hospital that does not operate on a formulary basis?

Grover C. Bowles Jr.

Because of the prevailing emphasis on the role of the P & T committee in initiating the formulary system, other important functions of the committee may be overlooked. The pharmacist as secretary of the committee and its only long-term continuing member has the obligation of stimulating the committee to action and seeing that its efforts are productive.

Here are some areas that deserve the attention of the pharmacy and therapeutics committee in all hospitals regardless of whether or not they have adopted the formulary system.

1. Automatic Stop Orders. The P & T committee is the logical committee of the medical staff to draft the regulations and list the drugs to be covered by automatic stop orders.

2. Approved Abbreviations. The use of approved abbreviations, thoroughly understood by all, helps to minimize medication errors. This list of approved abbreviations for use in writing orders and prescribing drugs should be compiled by the pharmacy and therapeutics committee.

3. Emergency Drugs. The emergency drugs stocked at each nursing station should be selected with care. The pharmacy and therapeutics committee should aid in the selection of these drugs, in the addition of new lifesaving drugs as they become available, and in the deletion of older agents that have outlived their usefulness.

4. Restricted Antibiotics. The pharmacy and therapeutics committee may want to recommend to the medical staff that certain antibiotics be reserved for use in those cases where laboratory sensitivity tests indicate that the organism is resistant to all other anti-infective agents.

5. Oral *vs.* Injectible Drugs. This could well be one of the committee's educational projects. It could demonstrate the desirability of using oral medication when possible from the point of view of good therapy and patient comfort as well as patient cost.

6. Investigational Drugs. At one time or another almost all hospitals participate in the clinical trial of new therapeutic agents. Carefully thought out policies governing the dispensing and use of these drugs are important. Again the pharmacy and therapeutics committee is the logical group to study this problem and to draft regulations as needed.

7. Bedside Medications. On occasion it is desirable to leave certain medications at the patient's bedside. To eliminate confusion, the committee could develop an approved list of drugs that may be left at the patient's bedside.

8. Detailing by Pharmaceutical Representatives. If detailing of the medical staff by pharmaceutical representatives is limited, the P & T committee could provide a useful function by spelling out the limitations and asking the medical staff and hospital administrator to approve them.

9. Use of the Metric System. To minimize confusion, it is desirable that all medication orders be written in one system. The metric system is the system used in the scientific literature and officially adopted by the U.S.P. and the N.F. This is another problem that could be studied by the pharmacy and therapeutics committee, and consideration should be given to developing policies making it mandatory to use the metric system in writing drug orders in the hospital.

10. Use of Sample Medication. While some of the major pharmaceutical firms are deemphasizing the use of sample drugs in their promotional efforts, hospitals still have to cope with the use of sample medication without proper controls and records. Drugs used for patient care in the hospital should be dispensed in properly labeled containers from the pharmacy. This is an area which deserves the attention of the P & T committee.

11. Cold Sterilizing Solutions Used in the Hospital. The doubtful value of many of the cold sterilizing solutions makes it mandatory that those solutions used in the hospital be selected with care. The pharmacy and therapeutics committee should compile a list of the acceptable agents to be used and should spell out the procedure for use in detail. Solutions not on the accepted list should not be used without the approval of the P & T committee.

12. Medication Errors. Medication errors can best be minimized when the cause for each error is known. The pharmacy and therapeutics committee should carry on a continuous study of medication errors occurring in the hospital and make specific recommendations when indicated. ■

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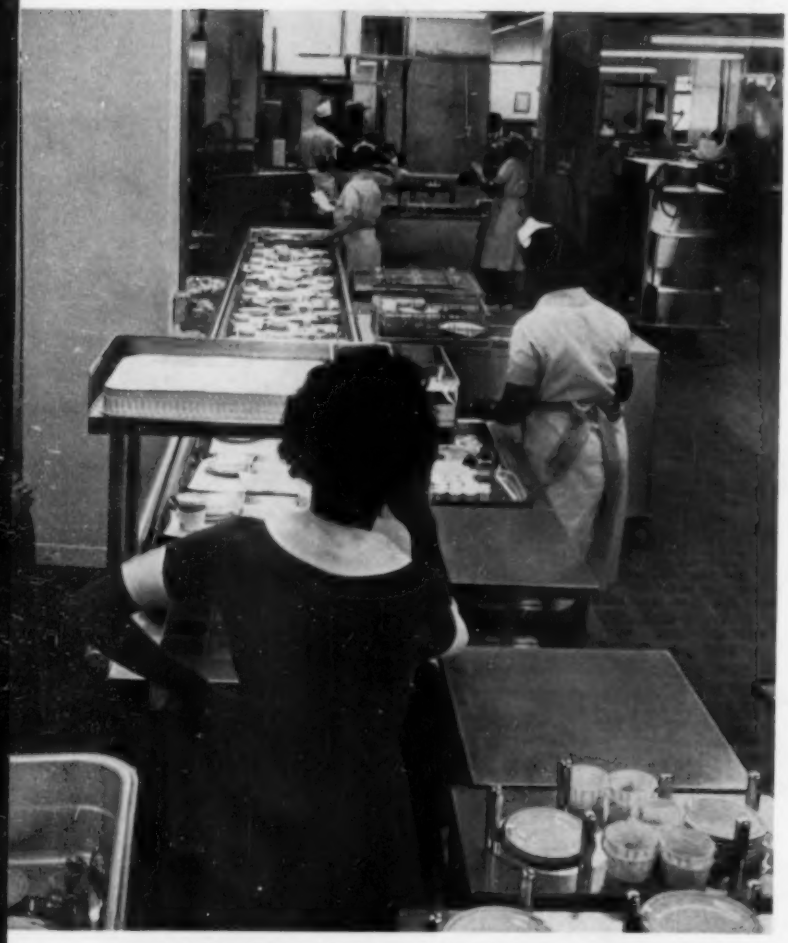
Conducted by Jane Hartman

New Kitchen Moves to Centralized Service

A temporary feeding problem gave Montefiore Hospital a chance to test some ideas and equipment planned for its modernization program



Main kitchen at Montefiore Hospital houses centralized assembly line. Trays are assembled here and transported by conveyor.

J. W. Bloch

IMMEDIATE and long-range needs, plus a decision to change to centralized food service, prompted the design of the new kitchen at Montefiore Hospital, New York.

The modernization program was begun early in 1957, soon after completion of the new cafeteria described last month (page 108). It was agreed that the decentralized bulk food service system should be replaced by a centralized service using mobile heated and refrigerated units.

A plan therefore was formulated under which the main kitchen would be completely rebuilt, enlarged and modernized, with new equipment and new refrigeration designed for the centralized system.

In the meantime the hospital was also faced with the problem of providing temporary feeding arrangements for a new 250 bed wing that was nearing completion. We decided to try out the centralized service in this area, using equipment which would be completely reusable under the long-range modernization plan in the main kitchen.

An extensive study was made to determine which centralized system would be best suited to our needs. We experimented with about 15 hot and cold food conveyors. One patient floor was converted into an experimental unit and the different conveyors were tried out for periods

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ranging from two days to four weeks. A report was written after each experiment, listing in detail all observed advantages, disadvantages and suggestions for modification to our particular purpose.

Consequently, a completely mobile cold tray assembly setup was recommended, principally because of the temporary nature of the original installation and the need for flexibility resulting from lack of space. A self-propelled conveyor was selected so meals could be transported from the main kitchen to patient floors by women dietary aides.

The new wing was completed in June 1959, but the seven floors were occupied gradually, giving the food service department time to adjust to the new operation.

With the successful installation of this system in the new wing, we have been able to go ahead with plans to expand the centralized food service and the renovation of the main kitchen with a minimum of disruption of service and with maximum utilization of our "temporary" equipment. ■

J. W. Bloch has been assistant to the director of Montefiore Hospital, New York, in charge of food service for the last seven years. Formerly, he was food production manager for Johns Hopkins Hospital, Baltimore, for five years. Prior to that he had gained experience and training in the hotel food management field. Mr. Bloch has also taught and lectured at several food service schools and institutes, and has written articles on food cost control and food procurement.

Two views of the main kitchen at Vassar Brothers Hospital show assembly line facilities of the temporary food service installation.

Temporary Kitchen Is Equipped To Serve Hospital Permanently

A PERMANENT kitchen in a temporary location might sound like a mistake, but at Vassar Brothers Hospital, Poughkeepsie, N.Y., it is part of a deliberate plan.

The new kitchen has been designed, fabricated and installed in temporary quarters so that it can be moved quickly and inexpensively to its permanent location.

When the hospital planned a new 100 bed wing it was decided to locate technical hospital facilities in the area that had housed the kitchen. The technical facilities were needed at once, but there was a delay in completion of the permanent space for the kitchen in the new wing. Hence, the kitchen equipment was installed temporarily in the hospital's old wing.

All equipment can be moved and reinstalled readily by simply disconnecting the mechanical connections, such as steam, gas and electrical services, and then reconnecting them to the services in the new area.

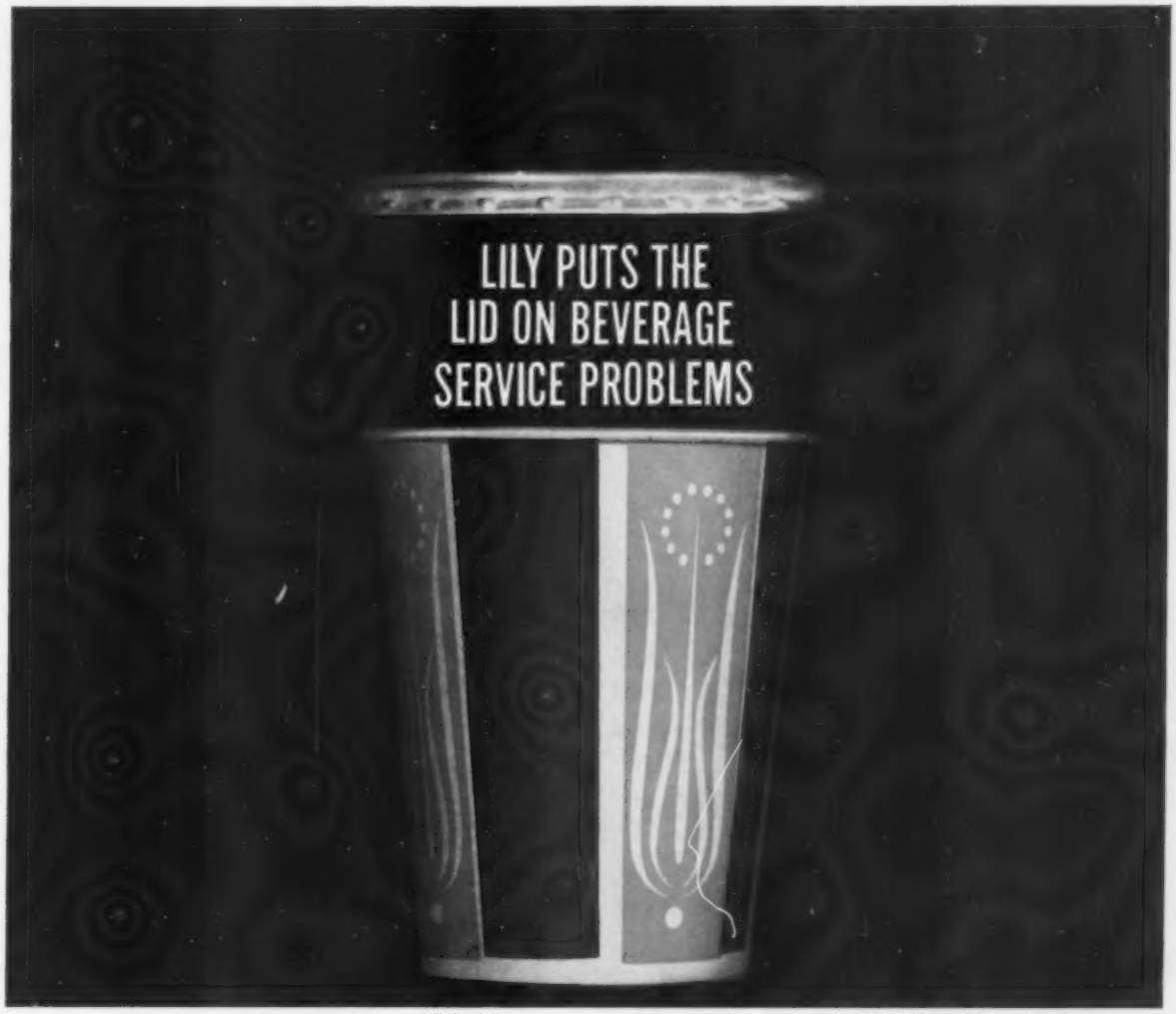
The new kitchen also represents a change from the hospital's former food service system. Previously, food was prepared both in a central kitchen and in decentralized pantries. Now all food is prepared in the central kitchen and transported to patients on hot and cold food conveyors. The new kitchen, although designed to serve one-third more patients than the old kitchen, occupies no more floor space.

"We have found our new kitchen to be most efficient," Winifred Bouvet, chief dietitian at the hospital, reports. The tray assembly can be handled efficiently by 11 or 12 employes, she says, and employes are pleased with both the new equipment and the arrangement.

The administrator, Louis E. Breglia, notes that from his point of view the new system appears both efficient and economical. "The meals are served quickly and with the hot and cold food carts the food reaches patients at its proper temperature."

The new system has also made it possible for the hospital to reduce its kitchen and food service labor force by 15 per cent.

The changeover from the old to the new kitchen was accomplished smoothly, the dietitian reports. "During the remodeling of the kitchen we put out 1000 meals or more a day as usual. Many partitions were torn down behind plastic film walls and there was a minimum of dust, the biggest inconvenience being the noise." ■



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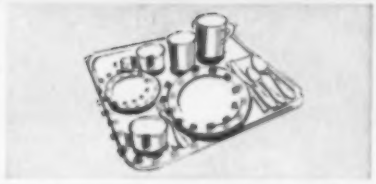

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How To Put Variety Into Soup Recipes

The dietitian who masters these three basic recipes can create a soup for nearly every purpose

A light soup, such as this cream of vegetable soup, makes an excellent choice to serve with sandwich and relish for a nutritious, simple lunch or supper menu.

SOUP is equally good at stimulating an appetite or satisfying one — if the dietitian knows which of the many varieties to select.

In general, soups used as appetizers are either clear broths or cream soups. For a main course, a hearty soup with a high protein content should be used.

Almost endless variation is possible in soup, depending on what ingredients are added to the base. Much of the success of the soup will, however, depend on the quality of the stock or cream base used. For this reason, Catherine Turner, assistant professor of home economics, University of Alabama, has reviewed some essential technics in the making of various types of soup.

Clear soups usually have a broth as the base. Miss Turner gives the following method for clarifying the stock for clear soup: Remove all fat from the cold stock. Add one slightly beaten egg white, with the shell, for each quart of broth. Mix well and heat to the boiling point while stirring constantly. Reduce heat to simmer and continue cooking. The egg white will coagulate in approximately 5 minutes. Remove from heat and add ½ cup of cold water for each quart of stock. Allow to stand for 15 to 20 minutes and then strain through a cloth.

Seasonings and flavoring should be added before the stock is clarified because they may cause cloudiness to reappear if added later. (*Continued on Page* 140)

CREAM OF VEGETABLE SOUP
(25 servings)

Ingredient	Amount
Celery, chopped	½ lb.
Onions, chopped	¼ lb.
Carrots, chopped	½ lb.
Potatoes, diced	1½ lbs.
Water	2 qts.
Milk	1 qt.
Beef stock	1½ qts.
Salt	1 tbsp.
Pepper	½ tsp.
Butter or margarine	1 cup
Flour, sifted	1 cup

Cook vegetables in water until almost tender. Add milk, beef stock, and seasoning. Heat to boiling. Melt butter or margarine. Stir in flour. Stir mixture into soup and cook until slightly thickened.

BASIC BEEF STOCK
(Approximately 1 gallon)

Ingredient	Amount
Beef, soup bone	5 lbs.
Cold water	5 qts.
Veal and bone	2 lbs.
Salt	1 tbsp.
Peppercorns (whole pepper)	1 tsp.
Carrots (one-inch pieces)	8 oz.
Onion, quartered	4 oz.
Celery (one-inch pieces)	6 oz.

Place the meat and bones in the cold water. Bring to a boil. Reduce heat and allow to simmer 2 or 3 hours. Skim fat from the stock as it forms. Add the vegetables and seasonings and continue to simmer until the vegetables are soft. Strain. If stock is not to be used immediately, store in refrigerator.

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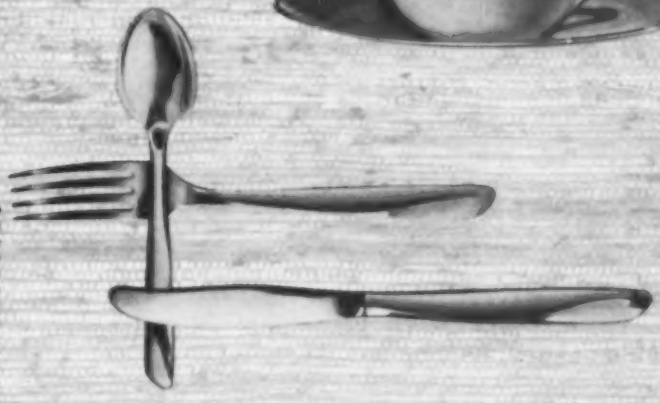

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(*Continued From Page* 138)

Some clear soups include bouillon, consomme, vegetables in broth, and combinations of beef, chicken or turkey with noodles or rice in broth.

Creamed soups are also excellent choices for appetizers or for use with meat or cheese sandwiches for lunch or supper. They usually have a thin white sauce base. If a starchy vegetable such as potato is used, the white sauce will need to be thinner than one for a vegetable that is low in starch.

As a basic recipe for cream soup, Miss Turner suggests 5 quarts of hot milk to 6 ounces fat, 3 ounces of flour, and 1½ tablespoons of salt. For starchy vegetables, the amount of flour should be reduced by one-third to one-half. This yields approximately 1¼ gallons.

A richer flavor in cream soups can be obtained by substituting light cream for part of the milk or by increasing the amount of fat used.

To prevent cream soups from curdling care must be taken not to heat the milk to too high a temperature or allow it to cook too long. If the salt is added just before serving, this will help prevent curdling.

Various meats, fish and vegetables can be used for cream soup. Among the vegetables often used are tomato, celery, peas, spinach, mushroom, corn, carrot or a combination of vegetables. (See recipe for cream of vegetable soup on page 138)

Hearty soups are usually a combination of meat and vegetables or a cereal product in a meat stock. Chicken or turkey is often used in place of meat. Most commercially canned soups of this type do not contain sufficient meat to be considered a hearty soup for a main course, Miss Turner advises. More meat can be added to these soups to provide adequate protein or the soup can be made from basic ingredients.

For making a beef soup stock the American Dietetic Association, in "Large Quantity Recipes," recommends: "Six pounds of lean red meat and marrow bone per gallon of finished broth is a minimum for adequate richness. Flavor rich extracts should be obtained from lean red meat, such as neck and shank, and not from fat cuts such as the brisket or plate."

The bones should be cracked to allow the liquid to reach the marrow and impart better flavor. As in making coffee, the flavor will be improved also be the use of cold fresh water rather than water that has been heated and stood in the storage tanks.

In addition to the flavor of the meat, a good stock also has the flavor of some well chosen vegetables and seasonings. (See recipe on page 138.) Tomatoes, okra, corn, lima beans, carrots, celery, onions, turnips, green beans, cabbage and potatoes are all possible choices. Regardless of the vegetables used, the cooking time should be considered. Overcooked vegetables in soup detract from the texture and flavor. The vegetables should have good color and texture and should not be mushy.

Oyster stew or bisque, clam, shrimp or various other fish chowders are another type of soup that can be used as a main dish. Since most of these have a milk base, caution must be used not to overheat the milk. In addition, oysters have a tendency to toughen with long cooking. If it is necessary to hold oyster stew for a time, it is best to heat the oysters separately until the edges curl and then add them at the time of serving, Miss Turner advises. ■

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How To Keep Diet Changes in Order

These procedures for reporting diet changes help the right patient get the right meal — without undue effort for the nursing service in recording changes or for the dietary department in carrying them out

Jane Hartman

SYSTEMATIC reporting of dietary orders is necessary to avoid confusion caused by last-minute changes and trays being returned from the floors with incorrect or unneeded meals.

Jane Hartman

The ideal system would bring a complete listing of every patient from every unit well in advance of each meal of every day. **Several hospitals have found that confusion is reduced when each nursing unit prepares a complete diet list for the main kitchen, signed by the nurse in charge, at a specific hour each day.** Every bed in each unit must be accounted for in the listing either by indicating a patient's name or by writing the word "vacant." In addition to the room and bed number of each patient, the current diet order should be written in the space provided and the serving status of his tray indicated. Serving status may be designated as "omit," "hold," "chemistry" or "serve."

Lists Admissions and Discharges

In this system, the name of a discharged patient and the name of a patient admitted to his bed are both listed. It is usually helpful to include "Discharge" and "New Admission" on the printed form so that a check mark or circle can be used.

More common but less than ideal is the system based on a "Diet Change Order" form. Omissions, scratched additions, and illegible jottings lead to diet errors.

The first system obviously will take more time in the nursing unit and, unless ward clerks are available, may be an additional clerical burden that the nursing department will resist.

The Stamford Hospital, Stamford, Conn., has devised a system that achieves all the objectives of this system with a minimum amount of repetitive clerical work by nursing.

Each unit is provided with a clear plastic envelope measuring approximately 11 by 17 inches. Inside is a printed guide sheet with four columns: (1) Changes (Mark in Red), (2) Floor-Room, (3) Name and (4) Diet. Generous horizontal spaces allow for 36 patients. (Hospitals with smaller nursing units would not need as much vertical length to the guidesheets and envelopes.) The only entries on this printed sheet are the numbers under the "Floor-Room" column. All other entries are made *on the plastic cover* with china marking or similar grease pencils. Because it is easily erased, this use of the plastic cover for the daily information is the trick that makes this system really work.

The proper hour for the new form to reach the diet office will vary with hospital meal hours. Where dinner is served at 5:30 p.m., 2:30 p.m. is a suggested deadline.

The Stamford Hospital procedure requires each nursing unit to prepare the sheet on the night shift and deliver it to the dietary supervisor at 6 a.m. After breakfast, the sheets are returned to each unit for updating. At 10 a.m. dietary supervisors pick up the lists for preparation of the noon meal and at 3 in the afternoon repeat the pickup for supper preparation.

Red Signals Changes

To distinguish between them, routine entries are in black pencil and changes are in red. A red check mark is used to call attention to admissions, discharges and diet order changes. The letter "T" is used in place of the check when a patient has been transferred in or out of the unit.

Whatever system a hospital devises, the need exists for *written* notification from the nursing department to the dietary department. The time of the notification will depend partly upon the flexibility of the dietary department, partly on the meal serving times, and partly on the admitting policies of the hospital. (An admitting department that has firm control of elective admissions and which is cooperatively inclined can be a real help to the dietary department, which will always have to contend with admission of patients at unexpected times.) Finally, the telephone must be used to "cover" even the best system. Telephone orders, however, should be confirmed in writing. Nursing-dietary department relationships are not strained when a proper system is established and followed. ■

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Chief Dietitian
Welborn Memorial Baptist Hospital
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7 Tomato Juice, Lemon Poached Egg on Toast • Beef Rice Soup Roast Leg of Veal, Gravy Mashed Potatoes Creamed Peas, Carrots Coleslaw, Cream Dressing Whole Apricots • Chicken Gumbo Soup Ham a la King on Toast Stewed Tomatoes Banana Log Salad White Cake	**8** Frozen Grape Juice Sausage, Blueberry Muffin • Pineapple Juice Roast Turkey, Giblet Gravy Mashed Potatoes Buttered Broccoli Assorted Relishes Neapolitan Ice Cream • Pepper Pot Soup Hamburger on Bun Potato Chips Creamed Asparagus Sliced Tomatoes Bing Cherries	**9** Half Orange Egg Pancakes, Sirup • Cream of Celery Soup Grilled Ham, Pineapple Ring Creamed Potatoes Green Beans With Slivered Almonds Celery Hearts Peach Melba • Pineapple Juice Beef and Noodles Cauliflower au Gratin Carrot Sticks and Green Pepper Rings Strawberry Sundae	**10** Tomato Juice Waffle, Sirup • Cream of Pea Soup Fried Catfish Escalloped Potatoes Broiled Tomatoes Prune and Cottage Cheese Salad Apricot Halves • Cream of Celery Soup Tuna Fish Salad Potato Chips Creamed Carrots Stuffed Celery Chocolate Pie	**11** Sliced Banana Ham, Buttermilk Biscuit • Grapefruit Juice Roast Rib of Beef au Jus Parsley Buttered Potatoes Baked Squash Carrot and Celery Sticks Butterscotch Sundae • French Onion Soup Chicken Pie, Biscuits Buttered Wax Beans Ribbon Mold Salad Pears	**12** Honeydew Melon French Toast, Sirup • Consomme' Stuffed Pork Chop Baked Sweet Potatoes Buttered Mixed Vegetables Creamy Lime Mold Blue Plums • Pineapple Juice Creamed Sweet Breads on Toast Points Buttered Mixed Vegetables Peach and Cottage Cheese Date and Nut Roll
13 Apricot, Pineapple Juice Fried Egg, Toast • Beef Noodle Soup Baked Baby Beef Liver, Fried Onions O'Brien Potatoes Breaded Tomatoes Bib Lettuce Pineapple Sticks • Chicken Gumbo Soup Grilled Cheese Sandwiches Broccoli With Hollandaise Sauce Jellied Vegetable Salad Apple Streusel Pie	**14** Pineapple Juice Ham Omelet, Toast • Chicken Rice Soup Breaded Veal Cutlet Potatoes au Gratin Glazed Carrots Hearts of Lettuce, French Dressing Cherry Pie • Vegetable Soup Bacon and Tomato Sandwich Potato Chips Fresh Spinach With Hard Cooked Egg Chocolate Ice Cream	**15** Grapes Scrambled Eggs, Toast • Tomato Juice Smothered Steak Mashed Potatoes Succotash Jellied Fruit Salad Pineapple Sherbet • Beef Broth, Croutons Chicken Livers and Mushrooms with Steamed Rice Buttered Green Beans Celery and Olives Royal Ann Cherries	**16** Peach Nectar Bacon, Muffin • Scotch Broth Baked Ham German Potato Salad Buttered Frozen Lima Beans Hearts of Lettuce, Bleu Cheese Dressing Cherry Cobbler • Chicken Gumbo Soup Veal and Vegetable Pie With Biscuits Sunshine Salad Butterscotch Pudding	**17** Sliced Banana Poached Egg on Toast • Grapefruit Juice Baked Halibut Baked Potatoes Buttered Peas Assorted Relishes Strawberry Pie • Cream of Pea Soup Cheese Omelet Buttered Beets Waldorf Salad Pineapple Tidbits	**18** Apricot Nectar French Toast, Sirup • Consomme' Baked Ham, Orange Sauce Candied Sweet Potatoes Buttered Brussels Sprouts Arabian Peach Mold Rhubarb Pie • Cream of Tomato Soup Meat Loaf Buttered Frozen Lima Beans Citrus Fruit Salad, French Dressing Creamy Rice Pudding
19 Half Grapefruit Bacon, Buttermilk Biscuit • Julienne Vegetable Soup Roast Leg of Veal Parslied Potatoes Buttered Brussels Sprouts Tossed Salad, Italian Dressing Buttered Pecan Ice Cream • Tomato Juice Grilled Steak on Bun French Fried Potatoes Coleslaw Fruit Cup, Wafers	**20** Frozen Grape Juice Soft Cooked Egg, Toast • Chicken Gumbo Soup Browned Spareribs Mashed Potatoes Escalloped Cabbage Tomato Aspic With Vegetables Apple Pie With Cheese • Cream of Potato Soup Chicken a la King in Patty Shell Buttered Green Beans Molded Cranberry Salad Vanilla Tapioca Pudding	**21** Sliced Oranges Pancakes, Sirup • Beef Rice Soup Braised City Chicken Leg Baked Potato With Cheese Buttered Peas and Carrots Pineapple and Banana Salad Coconut Cake • Oyster Soup Assorted Sandwiches Escalloped Corn Sliced Tomatoes Peaches	**22** Apricot Nectar Sausage Links • Beef Rice Soup Roast Lamb, Mint Jelly Buttered Potatoes Cauliflower au Gratin Molded Fruit Salad Lemon Meringue Pudding • Cream of Mushroom Soup Shrimp Salad in Tomato Cup Potato Chips Buttered Asparagus Bing Cherries	**23** Stewed Prunes, Lemon Omelet, Toast • Vegetable Soup Grilled Ham Steaks German Fried Potatoes Harvard Beets Asparagus Salad Sesame Seed Date Pie • Cream of Celery Soup Chicken Polanaise Steamed Rice Fresh Mustard Greens 24 Hour Salad Blue Plums	**24** Blended Citrus Juice French Toast, Sirup • Cream of Celery Soup Filet of Sole Parslied Potatoes Baked Green Beans With French Fried Onions Hearts of Lettuce, French Dressing Vanilla Ice Cream, Wafers • Tomato Juice Macaroni au Gratin Buttered Spinach Molded Fruit Salad Chocolate Pudding
25 Apple Juice Bacon, Toast • Pineapple Juice Pork Barbecue Lyonnaise Potatoes Buttered Corn Molded Vegetable Salad Sour Cream Raisin Pie • Chicken Gumbo Soup Creamed Chipped Beef on Toast Stewed Tomatoes Frozen Fruit Salad Lime Sherbet	**26** Frozen Pineapple Juice Scrambled Eggs, Toast • Tomato Juice Roast Chicken, Gravy Mashed Potatoes Buttered Peas and Mushrooms Celery and Olives Strawberry Ice Cream • Cream of Potato Soup Fruit Salad Plate Banana Bread Sandwiches Escalloped Corn Date Tapioca Pudding	**27** Honeydew Melon Waffle, Sirup • Chicken Noodle Soup Pot Roast of Beef Browned Potatoes Glazed Carrots Mixed Fruit Salad Chocolate Cake • Tomato Rice Soup Broiled Beef Liver Buttered Lima Beans Pineapple-Cream Cheese Salad Gingerbread, Whipped Cream	**28** Frozen Citrus Fruit Poached Egg on Toast • Jellied Consomme' Veal Birds Macaroni au Gratin Broccoli With Hollandaise Sauce Under-the-Sea Salad Pears • Chicken Rice Soup Spaghetti With Meat Balls Harvard Beets Perfection Salad Apricot Halves	**29** Half Orange Bacon, Sweet Roll • Apple Juice Grilled Salisbury Steak Baked Potatoes Buttered Wax Beans Butterfly Salad Date Cake • Beef Barley Soup Chicken Salad, Salt Crackers Cream Peas in Patty Shells Sliced Tomatoes Apricot Halves	**30** Tomato Juice With Lemon Fried Eggs, Toast • Cream of Asparagus Soup Breaded Pork Cutlet Candied Sweet Potatoes Buttered Corn Coleslaw Fruited Gelatin, Whipped Cream • Chicken Gumbo Soup Spareribs With Sauerkraut Mashed Potatoes Fruit Salad Lemon Chiffon Pie
31 Sliced Banana, Grilled Cakes, Sirup • Consomme', French Fried Haddock, Lemon Wedge, Mashed Potatoes, Broccoli With Hollandaise Sauce, Stuffed Celery, Lemon Sherbet • Cream of Mushroom Soup, Sliced Cheese Plate, Potato Salad, Head Lettuce Wedge, 1000 Island Dressing, Peach Halves. Ready-to-eat or cooked cereals served on all breakfast menus.					

Mechanized Maintenance Saves Money

Power tools helped this custodial service save man-hours and thus reduced maintenance costs, while improving sanitation, increasing over-all efficiency, and helping workers in the department earn higher status

Ken Richards

MUCH of the opposition to "mechanized" maintenance develops, I suspect, from sheer inertia — a reluctance to abandon traditional methods, a refusal to face facts.

Here, for example, are some of the objections raised to mechanized maintenance.

1. "The equipment costs too much" is far and away the commonest complaint. Power scrubbers, installed vacuum systems, power waxers, and the like *are* costly, but the equipment usually pays for itself in less than three years (in reduced cleaning time, smaller staff, and lower total salary expenditures).

2. "Results are not as good" is a contention that is not only feeble, but patently ridiculous. Sanitation standards are immeasurably higher where a fully mechanized maintenance program is properly carried out. It stands to reason that mechanized maintenance would be superior. Can a man with a mop clean as efficiently as a man with a power scrubber? Can cleaning dry mops by shaking them match the cleanliness of vacuum cleaning them (at the slot of a central vacuum system)?

Next, let's examine some specifics. First, the all-important matter of over-all results. For the period from June 1958 to June 1959, our "vital statistics" were:

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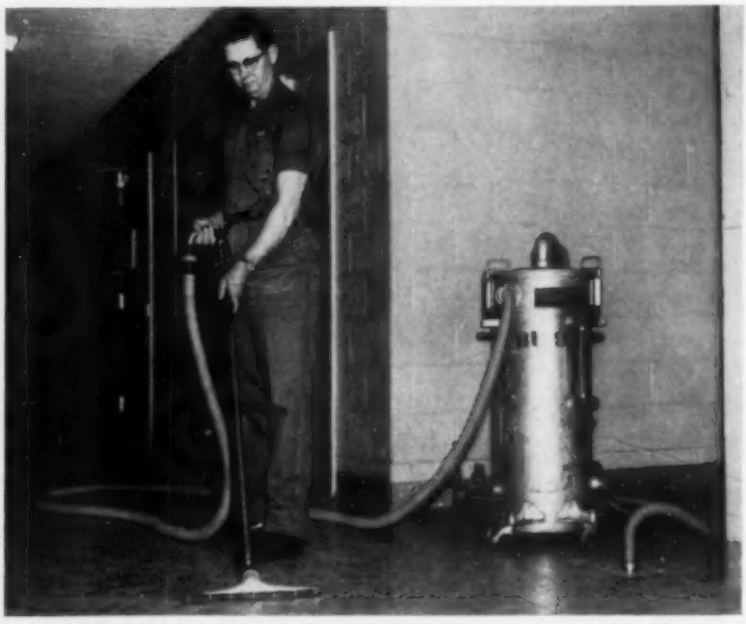
Labor cost included above: 16.1 cents

Even a quick glance at these figures makes one fact pointedly evident: Labor is far the most important por-

*Includes all supplies, equipment, and labor on custodial equipment made on campus (mop trucks, handles and mop holders for dry mops, and so forth.)



Custodian at Michigan State University uses portable water pickup separator in connection with central vacuum system.

Mr. Richards is head custodian, Michigan State University, East Lansing.

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BRANCHES IN ALL PRINCIPAL CITIES

tion of any cleaning budget. Labor is 87.5 per cent of our entire cost.

The question that naturally occurs next is: To mechanize a maintenance operation adequately, what equipment is needed? Obviously, it will vary according to individual situations (number of buildings, distance between them, interior arrangements of buildings, sanitation standards desired, and so forth), but perhaps our experience at Michigan State University may serve as a useful guide.

We have set for ourselves fairly stringent sanitation standards. Every building is classified A, B, C, D or E according to standards to be maintained, and the designations "normal," "high" and "very high" are assigned according to conditions required or desired in each building in each classification.

Our mechanical equipment consists of 22 central vacuum cleaning systems, three automatic scrubbing machines (more are contemplated), 82 floor machines (four to six planned for this year), seven portable water pickups, and four portable water pickup separators (for use with central vacuum systems).

Figures Show the Savings

Has this mechanization played a significant role in reducing our maintenance costs? Figures best tell the story: For the year 1942-43, the statistics show 156.3 maintenance man-hours per thousand square feet per year, compared with 97.7 for the year 1958-59.

It might be helpful to analyze the cleaning requirements of one or two individual buildings. One building at the university comprises 284,000 square feet of floor area. This is cleaned daily by 10 men and two women — more than 28,000 square feet per day per operator. That figure covers all necessary cleaning, scrubbing, stripping, waxing, washing of windows, and so forth, and contrasts sharply with what is commonly considered a good daily coverage: 14,000 to 16,000 square feet.

This building is by no means an exception. Another building, this one of 67,000 square feet area, was formerly cleaned by two men and one woman. With incorporation of a new vacuum slot system, it is now cleaned by two men (on a 10 p.m. to 6:30 a.m. shift), and cleaned better than before, I might add. The saving in salary in cleaning this one building alone is $2600 per year.

Nearly Doubles Coverage

One further example is Berkey Hall. Because it is used daily by 13,000 students, plus instructors and office help, this building is rightly regarded as a custodian's nightmare. Yet its 123,824 square feet is cleaned daily by six people (four men in the classroom areas; one man and one woman in the office areas).

A detailed analysis of man-hours spent on various assignments reveals exactly how certain savings result from mechanization. In the routine cleaning of Berkey Hall, for example, our present methods for routine maintenance (dry mopping and then cleaning mops at vacuum attachments) save 24 man-hours daily. In another building, use of automatic scrubbers saves 16 man-hours daily (over old hand methods).

A startling saving of time (more than 50 per cent) has been effected by introducing vacuum pickup of scrub water. And results are markedly superior to those achieved by hand methods (*mopping* floors dry after scrubbing).

The Human Element

So far, heavy stress has been laid on the advantages of mechanization. And those advantages are definitely substantial and tangible. But there is an equally important, intangible consideration involved in molding a maintenance department that will function at maximum efficiency — *people*, and their *personalities*.

No man enjoys being regarded as "just a janitor." And the dollar savings alone that a capable man can effect entitle him to higher regard than that. The problem, therefore, resolves itself into one of developing pride among custodial people. Creating an atmosphere of team effort helps; but even more important is the matter of providing incentives.

We introduce incentive by means of a rating system for buildings and supervisors. Factors considered in rating buildings are: size, number of custodians assigned to building, and standards of cleanliness expected. Rating buildings in this manner permits common denominators to be established for rating performance of personnel. Pride of performance becomes a factor, and an element of competition is even introduced.

Whenever any custodian feels he is ready for upgrading to a higher classification, he has only to approach his supervisor (or me) and a two-week trial period in the more responsible job is arranged. All new men, incidentally, receive on-the-job training with three or four experienced custodians.

We hold informal monthly meetings at which gripes are aired, suggestions offered, and information is shared. It has been our experience that these meetings do much to maintain high morale and encourage the feeling that ours is a "team" effort. ■

This Is the Way They Clean Their Floors

Left: Custodian utilizes central vacuum pickup system for floor cleaning. Center: Here he operates a typical floor machine for washing and polishing. Right: Here he is operating an automatic scrubbing machine. These operations are part of the routine at Michigan State University.

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Methods Are as Important as Materials in Controlling Infections in Hospitals

W. Armour Sherrer, M.D.

IMPROPER mopping procedures may be permitting the survival and spread of dangerous numbers of bacteria in many hospitals today.

This is one of the principal conclusions suggested by tests conducted recently at Kennestone Hospital, Marietta, Ga. The tests indicate, among other things, that damp-mopping is surprisingly ineffective in reducing bacteria counts on floors, even when done with a powerful detergent-germicide. **Wet-mopping, which could easily replace damp-mopping in the housekeeping routine, was found far more effective.**

More than 3000 bacteria cultures were taken and tabulated during Kennestone's study in an effort to evaluate the efficiency of various cleaning and disinfecting agents and procedures. A 19 room internal medicine wing was divided into test and control areas and cleaned by personnel selected especially for the test. Thus the hospital was able to determine bacteria reductions obtained on surfaces and in the air.

In addition to the facts about damp-mopping *versus* wet-mopping, some other useful information emerged from the tests:

– Brushes of floor buffing machines may harbor organisms and actually contaminate hospital floors.

– A bacteriostatic floor wax reduces bacteria counts on floors cleaned by detergents without germicides.

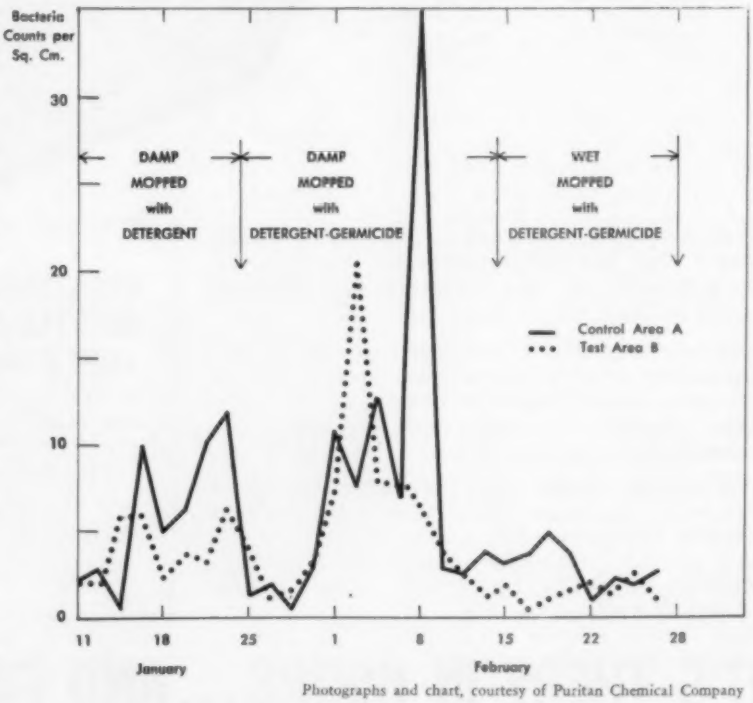
– Laundry procedures may be effective in maintaining extremely low bacterial counts with or without a germicidal rinse.

– Daily cleaning of air conditioning filters with a detergent-germicide may be indicated as the best way to reduce hospital air bacteria levels.

The test program was undertaken because of the much publicized fact that infectious agents are being maintained in many hospital environments.

(*Continued on Page* 152)

Figure 1 — Comparison of Bacteria Counts on Floors



Photographs and chart, courtesy of Puritan Chemical Company

Dr. Sherrer is associate pathologist, Kennestone Hospital, Marietta, Ga., and chairman of the Kennestone infections committee.

Because of the extensive nature of this test program the participation of many individuals was required for its success. The author would especially like to acknowledge the cooperation and assistance of Millard L. Wear, administrator, Kennestone Hospital; William C. Roach Jr., executive housekeeper, and R. Rackley, associate director of nurses.

The test program was sponsored by the Puritan Chemical Company of Atlanta, Ga., in connection with its studies of the engineering of hospital housekeeping programs and of the design of bacteria control products. Manuel N. Fineman, Ph.D., technical director of the company, and John J. Duncan, Ph.D., of the company's laboratory staff collaborated with Dr. Sherrer in conducting the program.

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Hospitals are faced all too frequently with the problems of unexpected surgical wound infections, breast abscesses, and skin pustules in obstetric patients and in the pediatric nursery. Pneumonia and endocarditis appear in medical wards. Pseudomonas and Proteus have gone beyond being mere nuisances; they are becoming primary invaders.

With these facts in mind, the test sought clear data about sanitary maintenance procedures and compounds being used. How effective were they in reducing bacteria counts in patient rooms? Would bacteria be more effectively controlled if bactericides or bacteriostats were incorporated into *every* housekeeping procedure? Where were such compounds not needed? How could housekeeping practices be altered to achieve greater bacteria control?

For the test, one medical wing of the hospital was divided into a control area, A, and a test area, B. The main lobby of the hospital was similarly bisected.

In the control area all surfaces — floors, mirrors, dressers — were cleaned or dusted throughout the test period with a synthetic detergent or polish which contained no bactericidal ingredients. At the end of the first two weeks this procedure was modified by one step — the use of synthetic detergent-germicide to dampmop the floor daily. All other procedures remained the same, with no bactericidal compounds being used on other surfaces.

In the test area, the same nonbactericidal compounds and the same procedures were used for the first week only. Then, in successive steps, the following types of products and procedures were introduced one by one:

A detergent-germicide for floors.

A furniture polish with bacteriostat for dressers and beds.

A glass cleaner with bactericide for mirrors and windows.

A germicidal rinse for linen.

Wet-mopping instead of dampmopping of floors. (This was one of the last variations introduced into the study.)

In addition to these steps, some of the air conditioning filters were cleaned with a detergent-germicide during the final two weeks of the seven-week test. Then, the air circulating in both controlled and test areas was scrubbed by introduction of a quaternary ammonium disinfectant into the hospital air conditioning system.

Detailed housekeeping procedures and special project instructions, patterned after an engineered maintenance program in operation at the hospital, were issued to each of the maids, custodians and laundry workers concerned with maintenance of the test wing and the lobby. Conferences with all personnel were held weekly to assure complete understanding of and strict adherence to the test program.

Bacteria counts in areas A and B of the medical wing were determined twice daily, four times per week, before and after cleaning in each of the patient rooms. The counts were taken from the floor, the mirrors, the dressers, and the bed linens. Counts were obtained by swabbing surfaces with sterile swabs, moistened in saline. Sterile templates, with a hole 1 inch in diameter, were used to make sure the swab areas were standardized throughout the test.

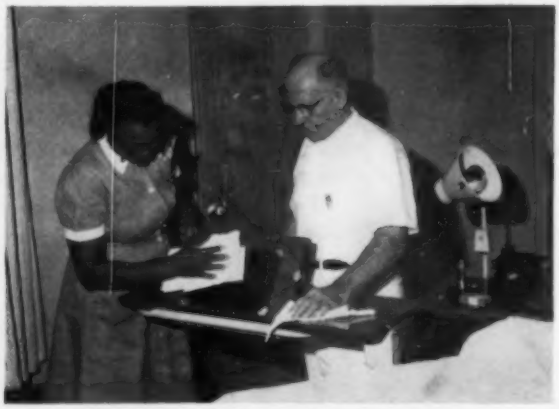
Samples of heart-infusion agar were inoculated with the contaminated swabs. The agar was transferred to sterile Petri dishes and incubated to grow the bacteria colonies, which were then counted. Air cultures were taken in 10 of the 19 rooms by exposing sterile Petri dishes containing the agar for 15 minutes.

All Petri dishes were coded in order to maintain objectivity in evaluation of the data. In addition, a record was kept of the patient's illness in each of the test rooms. During the seven weeks of the test, more than 3000 bacteria cultures were taken and tabulated. It was necessary to analyze all data statistically so that individual nonrepresentative counts could be discarded.

Here, and in the graph on page 150, are some of the results of the test:

Although detergent-germicides are known to be more effective than detergents alone in controlling bacteria under comparable conditions, the data reported in the graph show something significant. Even when detergent-germicides are used, the bacteria counts

To standardize the swab area, sterile templates with a hole 1 inch in diameter were used for the swabbing.



Maids were instructed in specialized procedures where necessary to assure complete uniformity of methods used.

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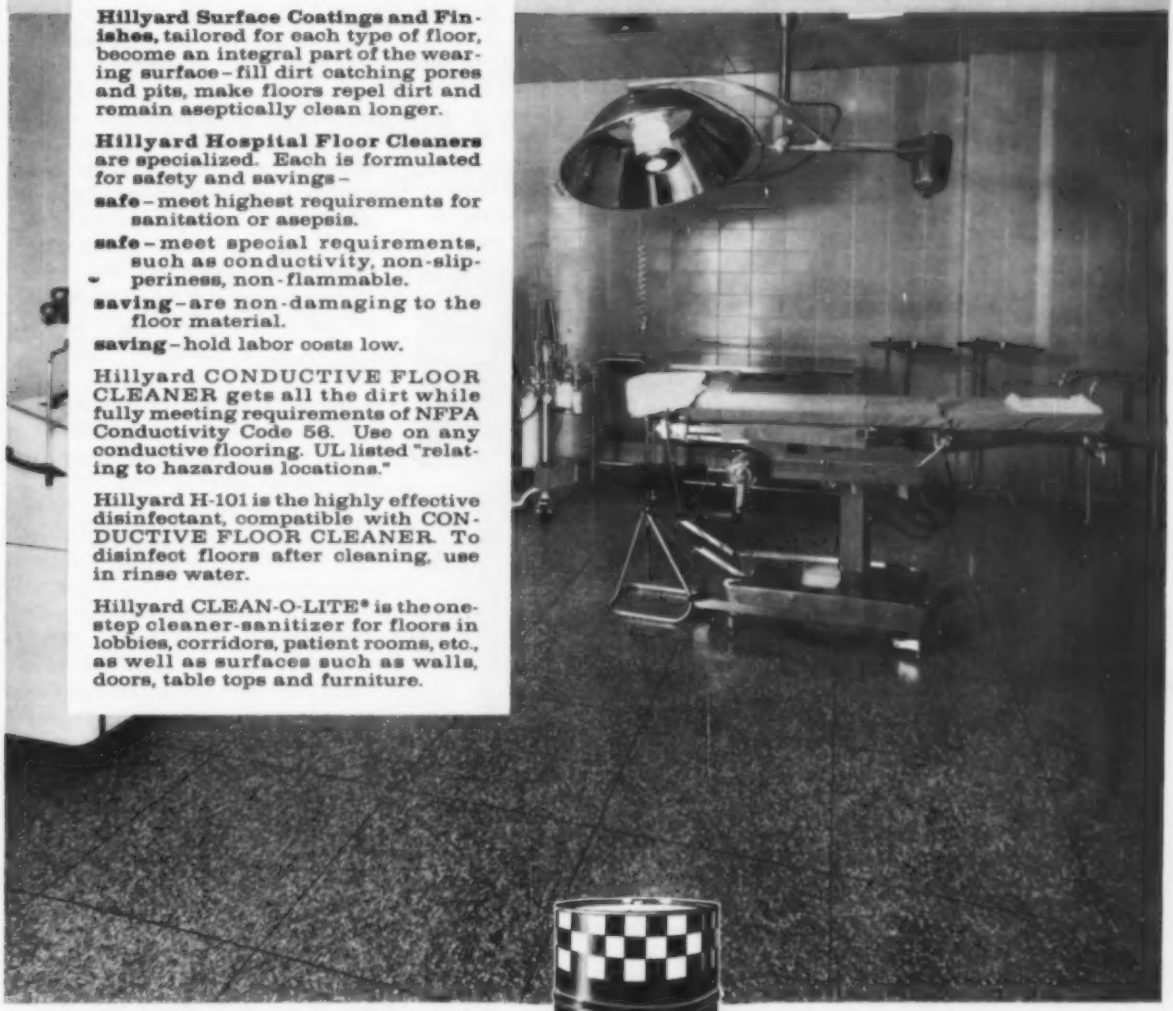
Hillyard CLEAN-O-LITE® is the one-step cleaner-sanitizer for floors in lobbies, corridors, patient rooms, etc., as well as surfaces such as walls, doors, table tops and furniture.



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can be quite erratic when such cleaners are applied by a damp-mopping technic. **However, when applied by a wet-mop technic, the detergent-germicide eliminated this erratic behavior and produced a substantial and uniform reduction in the bacteria count.**

The wet-mopping technic used in the test involved application of the detergent-germicide with a dripping wet mop. Then, after a few minutes, the solution was removed from the floor with either a wrung-out mop or with a wet vacuum.

Test results suggest that because a minimal quantity of detergent-germicide is deposited on the floor by damp-mopping, and because the detergent-germicide is left on the floor for a very short time, the compound is made ineffective by improper use. This caused the erratic bacteria count. Unfortunately, the damp-mopping procedure is all too common today in many hospitals.

Housekeeping operations were carefully supervised to be sure that test procedures were being followed.

The data show that wet-mopping, on the other hand, maintained bacteria levels at fewer than five per square centimeter, a figure acceptable for an operating room floor!

Hard, nonporous surfaces, such as mirrors and dressers, were maintained at relatively germ-free levels, even with nonbacteriostatic or nonbactericidal products, so long as the surfaces were kept free of soil by daily cleaning and dusting. Bacteria counts in the controlled area averaged one or less. Thus, it was obviously impossible to show any advantages by using a bacteriostatic polish or a bactericidal cleaner in the test area. Nevertheless, data from other sources indicate that these products will indeed provide additional protection in communicable disease wards or where housekeeping procedures or personnel are inadequate.

The laundry is one of the areas where hospitals have discovered a source of bacteria growth and spreading. **Linens were therefore included in the test to see whether or not they were "safe." The test showed that the laundry procedures used at the hospital were effective in maintaining extremely low bacterial counts even without a germicidal rinse.** Presumably the high heat of the wash water accomplished the sanitizing effect desired. (Here again, data from other sources suggest that where linens are contaminated a germicidal rinse kills bacteria in the washer and provides residual bacteriostatic action.)

The bulk of the air entering the hospital passes through electrostatic filters, which were unavailable for this test. These filters showed bacteria counts of 30 per square centimeter. No doubt a daily cleaning of these with a detergent-germicide would reduce this figure and would proportionately reduce bacteria levels in the air throughout the hospital.

The test data on the air conditioning system are considered incomplete, and the results suggest that a carefully controlled test of the air conditioning system in an entire hospital would be helpful in guiding hospital infections committees.

Two incidents in the hospital routine showed up conspicuously as day-to-day bacteria counts were kept.

The first incident was a sudden jump in floor bacteria counts that was traced directly back to the buffing of the floors with a buffing machine. The bacteria count found on this brush calls attention to a danger many hospitals may not realize. That is, the brushes of floor-buffing machines are used over and over again, often without disinfection, and this may be contaminating the floors.

Since buffing is usually done a short time after the floors have been cleaned, the use of a contaminated brush is particularly unfortunate. It literally "wipes out" the effect of the cleaning. The housekeeping time spent to clean the floor is wasted; the contamination so carefully cleaned

Tests of hospital linen show . . .

99.5% reduction in Staph count of soiled linens when SWIFT'S ENSTAPH is used

In tests conducted at five Chicago area hospitals, it was found that the use of ENSTAPH resulted in a 99.5% reduction in the *Staphylococcus* count of urine soaked diapers.

The diapers from hospitals using no germicides in their washing formulas showed an average *Staphylococcus* count of 5,460,000 per diaper—hospitals using ENSTAPH average only 25,200.

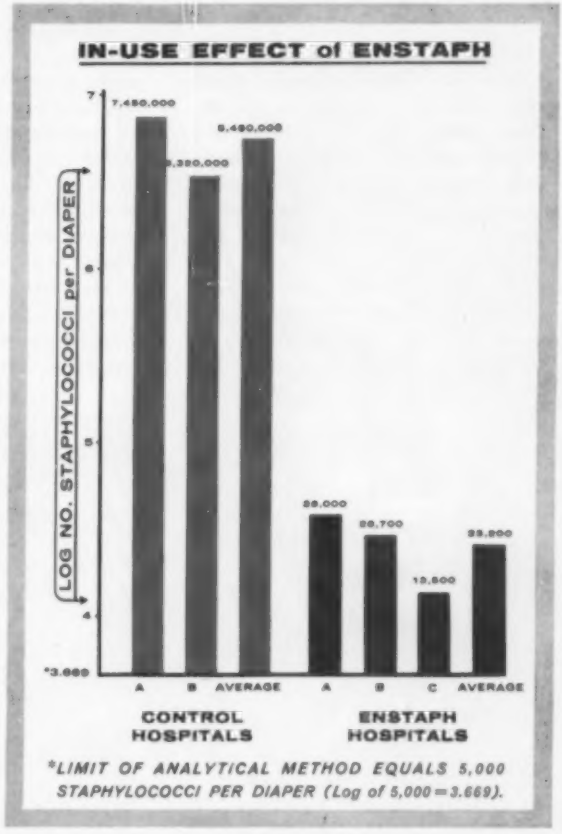
CONCLUSIONS

The results show the hazard that is created when linens soiled with fluids are held at temperatures permitting bacterial growth. *Staphylococcus* contaminated material becomes a focus of infection to the patient and *to the environment*, thereby to all patients and personnel. The regularity with which *staphylococci* can be found in soiled linens shows that the danger of an outbreak always exists.

THE ROLE OF ENSTAPH

Swift's ENSTAPH breaks the cycle of *Staphylococcus* transmission in linens. Fabric washed in ENSTAPH is impregnated with germicides which inhibit *Staphylococcus* growth at levels as low as 1 to 2 parts per million. Linens retain their anti-bacterial characteristics during dry storage. During use, when the cloth is moistened, the germicides are activated and exert their activity against contaminating *staphylococci*.

Our studies have shown that unprotected linens constitute a potential threat to the hospital environment. The use of ENSTAPH presents a solution to this problem. The hospital must decide whether it can afford to treat its linens with germicides in order to break the cycle of *Staphylococcus* transmission.



LET'S LOOK AT THE FACTS ABOUT COST AND USE

ENSTAPH adds 2¢ to 3¢ to the cost per hundred pounds of dry linens washed. It is as easy to use as ordinary washing materials because it is a completely built quality soap containing a germicidal system. ENSTAPH goes into the wash wheel just as it comes from the drum. No special formulas, additives or procedures are required. With the protection afforded at 2¢ to 3¢ per hundred pounds of dry linens, can the hospital afford *not* to use ENSTAPH?

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away is promptly reintroduced by a contaminated buffer.

To eliminate this source of contamination the brush was cleaned and soaked in a detergent-germicide. These findings suggest that buffing brushes should be disinfected regularly. Nylon buffing pads are especially desirable for hospital use because they can be easily removed and disinfected.

The second incident occurred when a colostomy patient, whose room had extremely high bacteria counts on all surfaces, was moved from one room in the control area to another room in the control area. Almost immediately, these same high bacteria counts commenced to appear in the new room. Significantly, the old room had been cleaned with a straight detergent, containing no germicide, during his stay there. A day after he was moved, a detergent-germicide was introduced into the floor-cleaning procedures throughout the control area — a step taken for the general safety of patients in the area. The use of the detergent-germicide in the new room brought about a notable reduction in the bacteria count, from 140 per square centimeter to four.

The meaning of the data surrounding this incident is clear. Patients involved in surgery of this nature, or in diseases that create high bacteria counts throughout the room, can be prevented from spreading bacteria to so great an area if detergent-germicides, applied by a wet-mopping or floor-flooding technic, are used.

The segment of the test that was conducted in the lobby yielded some meaningful data about the use of a bacteriostatic floor wax.

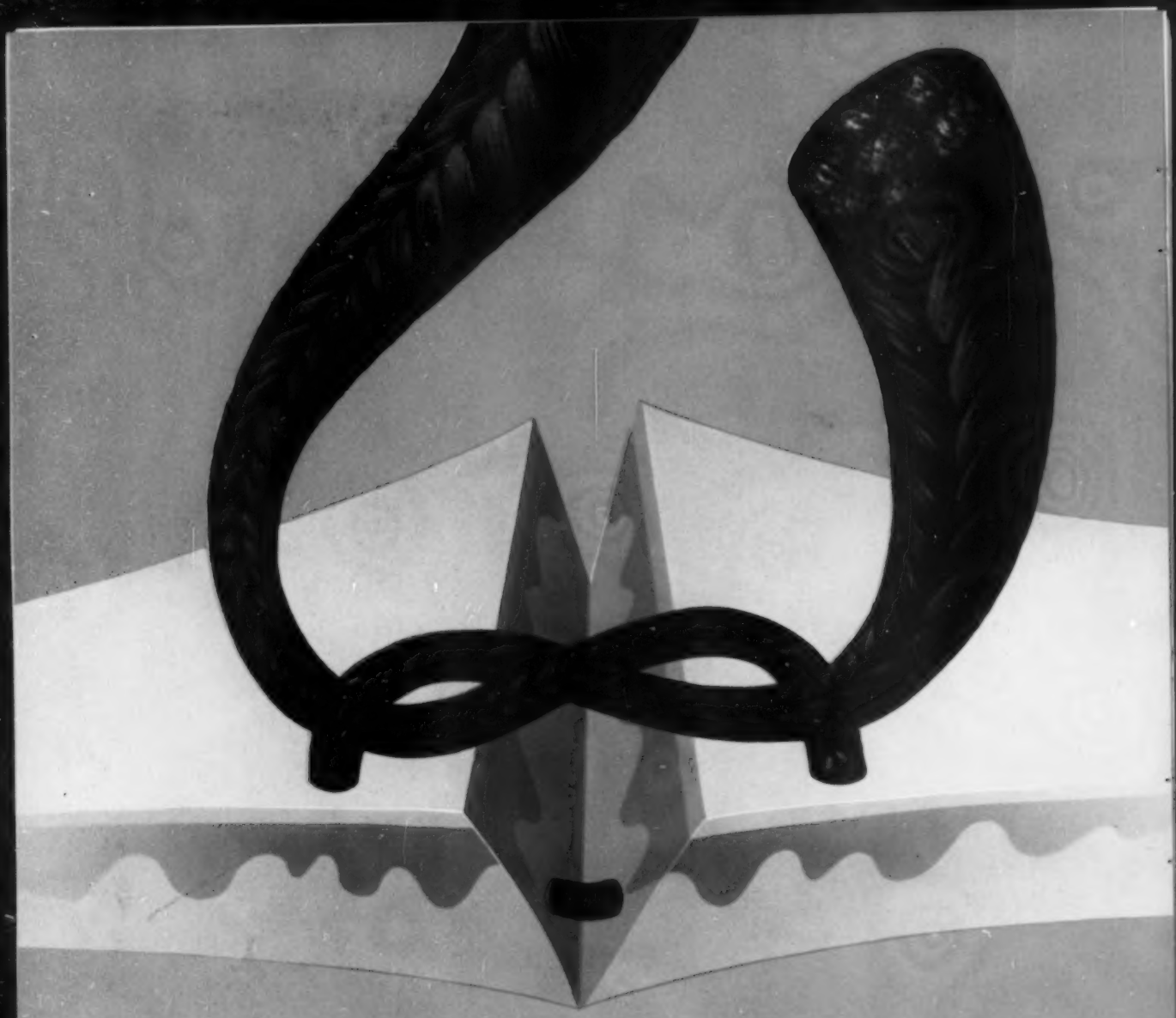
Half of the lobby was waxed with a polymeric floor finish, and the other half, or test area, was waxed with the same polish containing a bacteriostat. For the first few weeks a synthetic detergent was used to clean the waxed lobby floor. In later weeks the detergent was replaced by a detergent-germicide.

The heavy traffic in the hospital lobby produced occasional high bacteria counts on both test and control areas. When all lobby bacteria counts were averaged for each test week, however, average counts were much lower on the test area, which had been treated with a bacteriostatic wax.

Even more significant is the finding that when a detergent-germicide was used in addition to the bacteriostatic wax, no individual bacteria count exceeded five per square centimeter.

The conclusions drawn from this test — especially those about wet-mopping — have recently been verified by data from experiments in other hospitals. These studies suggest that the technic of flooding floors with detergent-germicides and then picking up the liquid with a vacuum cleaner is the most effective method of destroying disease-producing bacteria.

It also seems likely that better bacteria control was achieved because written work schedules, requiring exact cleaning methods and frequencies, were provided to housekeeping personnel in the test area and the work was carefully supervised. Methods, schedules and supervision evidently have as great an effect on bacteria control as do the compounds used. While new methods and new germicidal cleaning compounds will not alone put an end to institutional cross-infection, they can bring about far higher standards of sanitation in hospitals. ■



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(*Continued From Page* 106)

be seen. Certainly, governmental regulation of hospital activities increases each year. Many statutes which regulate the activities of business corporations, such as unemployment compensation and F.E.P. legislation, specifically exempt hospitals and other charities. However, pressure to do away with these exemptions is growing. Statutes have been enacted which regulate only hospitals, such as hospital licensing laws, which control hospital physical standards and operation. Statutes concerning hospitals multiply with each legislative session. Hospitals can no longer feel certain that they are immune from any type of governmental regulation.

Significant pressure for the enactment of legislation requiring hospitals to render emergency care is most likely to arise after a hospital has refused emergency treatment, and the refusal has resulted in a well publicized injury or death to the person involved. When a climate of public indignation exists, the very governmental exemptions and subsidies that hospitals enjoy can become weapons against them.

An excellent example of such a weapon is the exemption from real estate taxation, an exemption hospitals at present possess in all the states. The rationale for this exemption is that the hospitals perform a necessary community function, one which the government would otherwise have to discharge. The legislature might well consider emergency care to be part of this function and forbid an exemption to hospitals that do not maintain such a service. Withdrawal of tax exemption could have another effect. In those states where hospitals enjoy charitable immunity from negligence suits, proof of loss of tax exemption might be used to show that the hospital was no longer a charity and, consequently, that the immunity doctrine was not applicable. That hospital could then be sued for the negligent acts the same as any other business corporation.

More Litigation Likely

One point is becoming increasingly clear. Emergency care touches the public directly and dramatically. Because it does, and because this is an era of heightened hospital litigation, suits involving emergency care can be expected to multiply. Adequate emergency facilities are generally assumed by the public. When facilities don't exist, or are inadequate, or where care is unduly delayed or negligent, litigation is likely. Since 1956 there have been more appellate cases involving hospital emergency care situations than in all the previous years in which cases have been nationally reported.

Concern with respect to emergency care is presently reflected both in hospital literature and in the press. Whether this interest will eventually result in judicial recognition of a duty of hospitals to provide general emergency care or even first aid is questionable; but it is at least possible. Increased legislative interest in emergency care seems inevitable. Whether a community is adquately served by emergency facilities should be a matter of legal as well as ethical concern to the hospital or hospitals located therein. Legal concern about emergency care is just commencing.

(This discussion will be continued by Mr. Horty in his column next month.) ■

How a Doctor Chooses His Doctor

(*Continued From Page* 95)

of his respective American board. One in 10 was considered to be both of these and, in addition, a teacher on the faculty of a medical school.

In summary, then, physicians, especially diplomated and nonsurgical specialists, seem to choose as their personal physicians full-time specialists in internal medicine who are diplomates of the American Board of Internal Medicine and fellows of the American College of Physicians. They have had long-standing personal and professional relationships with these men and think very highly of their technical competence.

Information was collected about all hospitalizations of the respondent physicians and their families during the three years immediately preceding the interview. Of the total reported, 244 were for inhospital surgery. Table 3 shows some of the characteristics of the surgeon who performed the surgery; Table 4 refers to some of the characteristics of the surgeon-respondent relationship. These characteristics are examined with respect to type and location of surgery. The category "major elective" differs from "all surgery" in that it does not include emergency or ear, nose and throat procedures. It is designed to include surgery about which decisions are perhaps more important and which have been made without the sense of urgency that emergency situations produce.

In considering the location of the hospital at which the surgery was performed, it is assumed that social, economic, geographic and other factors might be expected to influence a physician to remain in his own community for his medical care. It is further assumed that when a doctor does leave his community, the characteristics of that care must be extremely attractive and desirable to him. In brief, it is assumed that this out-of-community care represents medical care of high quality.

Our data show that 43 per cent of the major elective surgery reported for respondent physicians and their families was done outside the respondent's own county; 31 per cent was performed in hospitals outside the state of New Jersey. There is no information on the frequency with which nonmedical people leave New Jersey for their surgery but more than one-half of the respondents agreed that physicians are more likely than nonphysicians to do so. When asked the reasons for this, two-thirds gave as the main reason (and the most frequently mentioned) the physician's greater awareness of better facilities and more qualified doctors outside the community.

Chose Specialists for Surgery

What are some of the characteristics of the surgeon chosen by the respondents to operate on them or on members of their families? Table 3 shows that:

1. Nearly 80 per cent of the surgeons chosen limit their work to a surgical specialty.
2. Not a single general practitioner was identified as having performed surgery on a respondent or a member of his family.
3. Two-thirds of all chosen surgeons were diplomates of their respective American board; among surgeons chosen outside of New Jersey, 87 per cent were diplomates.
4. Two-thirds of all chosen were

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fellows of the American College of Surgeons; four-fifths of those practicing outside of New Jersey were fellows.

5. When the surgery was done outside of New Jersey, eight out of 10 surgeons were on the faculty of a medical school and one-half of them were directors of their departments.

6. One surgeon in four was in the salaried practice of medicine in the out of New Jersey group.

7. Three-fifths of the out of New Jersey procedures were done in hospitals of more than 500 beds.

Table 4 shows that:

1. Ninety-five per cent of respondents considered their surgeon to be at least a full-time specialist.

2. When the surgery was performed outside of New Jersey, four out of five respondents considered their surgeon to be a full-time specialist and, in addition, a diplomate of his American board and a teacher in a medical school.

3. Nearly all surgeons were considered to be above average in competence; one-half were considered to be exceptional.

4. Nearly four out of five respondents mentioned technical competence as a reason for selecting the surgeon, although somewhat fewer mentioned it when the surgeon chosen was outside of New Jersey.

In summary, the physician's surgeon is highly specialized in his field, a diplomate of his American board, and a member of the American College of Surgeons. When consulted outside of the patient's own community, he is usually a teacher working in the hospital of a medical school and is generally the director of his department. He is on a salaried arrangement far more frequently than is the physician who seeks his aid. He is never a general practitioner. He is highly regarded by his patient although not as well known to him as his personal physician. He is described as being more frequently chosen for his reputation and less often for direct knowledge or appraisal of his technical competence than is the personal physician.

Finally, Table 5 records the professional status of the anesthetists who gave anesthesia to this sample of patients. Nine out of 10 were physicians when the anesthesia was for surgery, three-fourth when given for obstetrics.

May Reflect Changing Views

A representative sample of actively practicing physicians who are members of their state medical society has been surveyed with respect to choosing medical care for themselves and their families. Such care represents selection by experts in a situation in which the chooser has a considerable personal interest. Examination of the characteristics of the care chosen under these circumstances indicates that perhaps physicians are shifting their points of view on certain much discussed issues such as regionalization of medical care, the effect of the method of physician remuneration on quality, and the relationship between degree of specialization and the granting of inhospital surgical privileges.

It is suggested that the objective characteristics of the medical care chosen by physicians for themselves and their families represent care of high quality and that they can be used as reassuring guidelines by other groups who are seeking care of similar quality or who wish to estimate the quality of the care which they are presently receiving. ■

Automation Brings a Boom to Special Surgery

(*Continued From Page* 92)

and the induction rooms. The greater portion of one wall consists of a series of six angled sliding panels measuring 4 feet by 3 feet, 6 inches each. Two panels overlook the induction room and the remaining four overlook surgery, beginning at a height of 7 feet above floor level in these areas.

The laboratory serves as a control area for equipment available to the surgical and induction rooms. In addition to accommodating facilities for testing and servicing electronics equipment, it contains such special devices as:

1. Hypothermia refrigerating unit, hot water heater, and circulating pumps.
2. Closed-circuit television controls.
3. Oxygen analyzer recorder and sampling equipment.
4. Electrocautery and electro-cutting units with remote controls at the Scott boom.
5. Tape recorder and intercommunicating amplifier and controls.
6. Electroencephalography apparatus.
7. Neurological stimulant equipment.
8. Constant voltage supply regulators.
9. Emergency battery powered generator and automatic battery-charging equipment.
10. Power supplies for boom and x-ray tube stand motors.
11. Power supplies for electrical energy to experimental and development equipment.

Controls for different mechanisms are operated by the resident engineer who is present in the laboratory during surgery. A series of racks containing monitoring equipment enables him to ascertain immediately the working condition of the facilities at all times. He is in constant microphone communication with the surgical team to manipulate the many devices as directed.

Laboratory Frees Surgical Team

The electronics laboratory serves to minimize equipment and personnel in the operating room and frees the surgical team for its primary purpose of serving the patient. Research personnel can observe surgery and pertinent recordings from this vantage point, and the laboratory also serves as a general observation gallery.

Operating Table: Of the latest portable electric design, the table was modified by the medical engineer to permit the taking of radiographic series without the necessity for repositioning x-ray plate holders after each exposure. Connectors were added for suction waste bottles and special anesthesiologic equipment.

Photography: The special operating room contains a 16 mm. movie camera and a 35 mm. deep-recess still camera with integral light sources, and is also wired for installation of closed-circuit television cameras to permit the viewing of surgery from the first floor conference room.

The passing decades in the history of St. Barnabas Hospital have witnessed many accomplishments of modernization and development in keeping with the rapid forward strides of positive medical and surgical care for diseases heretofore considered incurable. Completion of the Kane Surgical Center is but the latest step toward the hospital's continuing objective of new horizons for surgical research and medical care. ■

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The Modern Hospital News Digest

Medical Care Costs Are Down, Hospital Care Costs Are Not, A.M.A. Study Shows

CHICAGO. — Although the cost of medical care is less today than 20 years ago, the cost of hospital care is higher, according to the American Medical Association. Figures released by A.M.A. show that a factory worker in 1959 had to work 22 per cent longer than in 1939 to purchase the same quantity of hospital services. Improved quality of care, however, has shortened hospital stays and thereby reduced the quantity of hospital care needed in individual cases, the A.M.A. pointed out. Examples cited: Average length of stay for a hemorrhoidectomy 20 years ago was 19.6 days; today it's 7.6 days. Average length of stay for an appendectomy in 1939 was 13.5 days; today it's only 6.7 days.

Cost of medical care shows even greater savings, A.M.A. pointed out, citing figures that indicate a factory worker in 1959 had to work only two-thirds as long as a similar employe in 1939 to purchase the same amount of medical care. ■

New F.D.A. Drug Information Regulation Draws Flurry of Substitute Proposals

No sooner did the Food and Drug Administration express official concern (in the form of a new regulation) for the lack of information furnished to physicians about prescription drugs than two different organizations volunteered to undertake the job. For the moment, the F.D.A. has ruled that the responsibility rests with the ethical drug manufacturers. ***(Page 171)***

Patients Pay Extra Costs for Infections Acquired During Hospital Stay

ST. LOUIS. — Patients who have to be moved from multiple-bed to private rooms because of hospital-acquired infections should be charged the usual higher rate for the private accommodation, the Jewish Hospital here said in a policy statement last month.

The question was raised by the medical staff and answered in a staff newsletter by David A. Gee, associate director of the hospital.

At the time the hospital infection committee was organized two years ago, the policy of charging the regular rate for more expensive facilities was established, Mr. Gee explained.

In hardship cases, where the patient is unable to afford the added rate, a review may be made by the credit office and, if circumstances warrant, the two-bed rate may be maintained, he added. Several such requests have been made during the last two years, it was reported.

Since some members of the medical staff considered it was inappropriate to charge the higher rate when the patient was moved because of infection acquired at the hospital, Mr. Gee explained the reasoning underlying the hospital's policy.

"It has been established that pathogenic strains of staphylococci are part of the environment of all hospitals," he said. "Thus they are a part of the risk that accompanies every patient's admission to a hospital. Hospitals are negligent only when they have failed to take steps to protect patients from acquiring infections. The Missouri State Division of Health has stated that hospitals which do not have staphylococcal infection control programs may be guilty of negligence and must assume the responsibility for patients acquiring these infections.

"The Jewish Hospital has gone into the matter of infection control very thoroughly. This elaborate control program has made us very aware of the potential seriousness of staphylococcal infections and we take many precautions . . . . We make no additional charge to patients for performing cultures, sensitivities and phage typing that must be done in connec-

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tion with staphylococcal infections. We have added more personnel to adequately handle environmental sanitation problems, have increased the laboratory staff to do the tests in connection with infections, have added many new items of equipment and greatly increased the usage of certain supplies in carrying out this program. It cost the hospital some $80,000 to initiate this program the first year it was started. It costs an additional $44,000 each year just to maintain the infections program in operation.

"All of this additional cost of carrying on this protective program is reflected in all of our charges to patients. The patient who must be moved to the private room in order to be on isolation receives a substantial amount of additional and expensive care. As long as he can afford to pay for this care, we are asking him to do so."

Affiliated Nursing Homes Invited To Join Michigan State Hospital Association

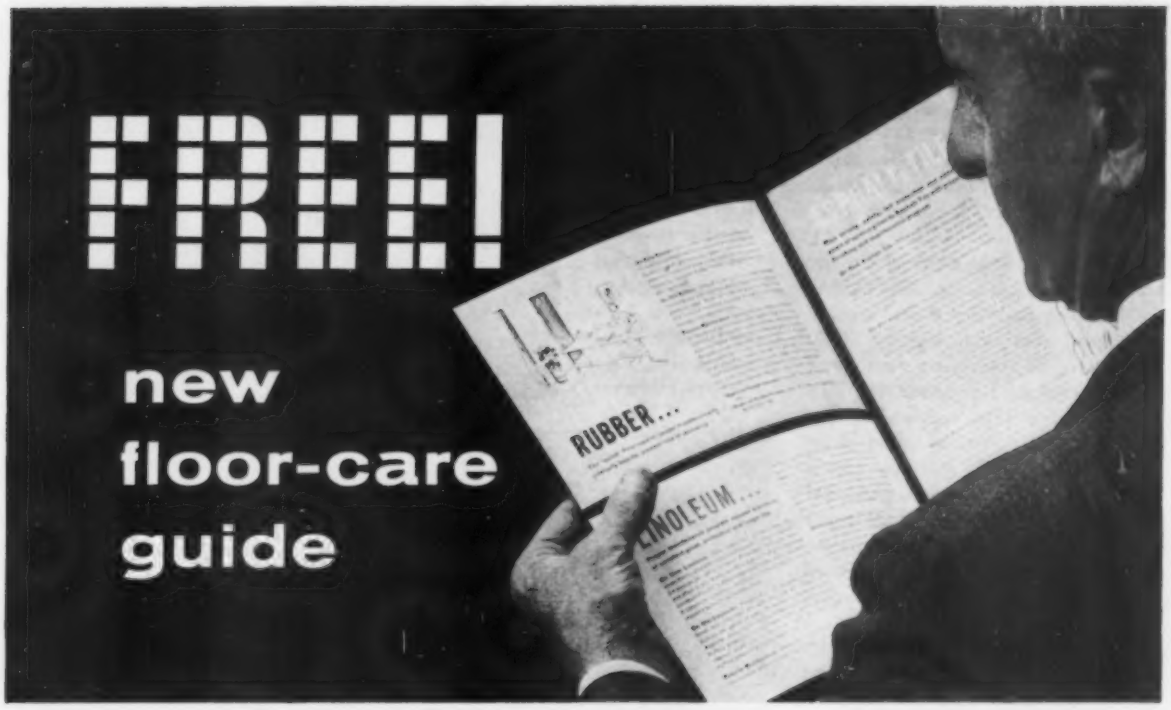
LANSING, MICH. — Membership in the Michigan Hospital Association has been opened to nursing homes affiliated with member hospitals.

The new criteria for membership were adopted by the association's board of trustees in December, acting upon a recommendation of the hospital relations committee with the Michigan Nursing Home Association. **Membership is now open to an institution that:**

1. Is licensed by the state.
2. Is able to meet the listing requirements of the American Hospital Association.
3. Has been approved by a committee of nursing homes.
4. Has an affiliation agreement with a general hospital member of the Michigan Hospital Association in its community.

Modern Hospital Index

The index to the second six issues of last year's magazines (July through December 1960, Vol. 95) has been printed separately. Send a note or post card for your complimentary copy. Persons who have asked for the previous index will be sent the latest index without further correspondence.



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N.J. Hospital Study Shows Occupational Therapists, L.P.N.'s in Shortest Supply

TRENTON, N.J. — Shortages of hospital workers in New Jersey appear to be most acute for occupational therapists, practical nurses, and medical social workers, a recently completed study shows.

On the basis of the number actually employed compared to the number the hospitals said they would employ if people were available, the study disclosed a 23.4 per cent shortage of therapists, a 21.3 per cent shortage of practical nurses, and a 20.5 per cent shortage of medical social workers.

Other major areas of personnel need included dietitians, 18.1 per cent; graduate professional nurses, 16.3 per cent, and medical record librarians, 15.2 per cent.

Of the 108 hospitals included in the study, not all employed all types of workers. While all 108 hospitals had a combined shortage of 1478 registered nurses, the 33 hospitals which employed occupational therapists had a shortage of only 26, but this was 23.4 per cent of the total number these hospitals needed.

The study, conducted by the New Jersey Hospital Association, was reported in the association's *Newsletter*, which also included figures from a similar study in 1956 of 70 hospitals. A comparison shows that percentage-wise the shortage in every area except the medical record librarians had become less acute over the four-year period.

Hermansen Elected Head of Nebraska Association

OMAHA, NEB. — Lloyd N. Hermansen, Dodge County Community Hospital, Fremont, Neb., was named president of the Nebraska Hospital Association at the 24th annual convention of the association held here recently.

Other officers elected at the meeting were: president-elect, John W. Estabrook, Nebraska Methodist Hospital, Omaha; vice president, Donald W. Duncan, St. Elizabeth Hospital, Lincoln; treasurer, Henry Reimer Jr., Mennonite-Deaconess Hospital, Beatrice, and secretary, Paul L. Piper, Boone County Community Hospital, Albion.

Officers Get Together at Florida Meeting

Florida Hospital Association officers shown above, left to right, are: I. James Anderson, Vero Beach, president-elect; Joseph McAloom, Hollywood, president, and J. A. McDonald, Apalachicola, secretary-treasurer.

Two Groups Offer Substitute Proposals to F.D.A.'s New Drug Information Regulation

WASHINGTON, D.C. – The Food and Drug Administration has recently required drug manufacturers to furnish physicians with more information on their prescription drugs – but the A.M.A. says it wants that job. So does the U.S. Pharmacopeia.

The new F.D.A. regulation provides that any labeling of prescription drugs or devices including promotional literature mailed or given to physicians by company representatives that furnish information about uses or dosage must contain complete information about any relevant hazards and contraindications.

If the drug is new, information about uses, dosages, hazards and contraindications must be substantially the same as that contained in the application to market the drug, the F.D.A. says.

The American Medical Association, in a letter signed by its executive vice president, Dr. F.J.L. Blasingame, proposed to start two new publications and improve its present *New and Nonofficial Drugs* to provide all doctors with full knowledge of composition, dosage, mode of actions, indications for use, and hazards of all drugs.

Dr. Blasingame urged the substitution of the A.M.A. plan for the F.D.A.'s own proposal for a package insert, which, he said, "will not effectively serve its intended purpose."

F.D.A. officials were enthusiastic about the scope and detail of the A.M.A. proposal, *Drug Trade News* reported, although they reserved comment on how it would affect the agency's position.

The agency also received an offer from the U.S. Pharmacopeia to supervise a program of distributing information on drugs through a central agency.

Adley B. Nichols, secretary of the U.S.P.'s board of trustees, wrote that the service would consist of regular mailings of easily kept materials, financed by reasonable fees charged the distributors of drug products.

The A.M.A. proposal would provide:

1. Preparation at least monthly of a new publication, *Authorized Brochures on Drugs*, which would be distributed free to all physicians.

2. A yearly "Handbook of Drugs," based on information published in *Authorized Brochures on Drugs* and including the summaries of the Council on Drugs.

3. Continued publication of *New and Nonofficial Drugs*, but in an improved format with more extensive information.

Missouri Association Names Deaver President

KANSAS CITY, MO. – A. Neal Deaver, Independence Sanitarium and Hospital, Independence, Mo., was installed as president of the Missouri Hospital Association at the association's 38th annual meeting.

Mr. Deaver is a trustee of the Missouri Tuberculosis Association, a member of the board of trustees of Blue Cross, a member of the American College of Hospital Administrators, and a member of the board of trustees of the Heart of America Tuberculosis Association.

Court Ruling Explains What It Takes To Make an Inhospital Staff Discussion 'Privileged'

TRENTON, N. J. — Deliberations among hospital administrators, trustees and medical staff officers and committees are privileged provided the discussions are relevant to the duties of the participants and without malice to any individual whose work is under discussion, a Superior Court ruled here last month.

Superior Judge Frederick R. Colie dismissed a complaint against the East Orange General Hospital, East Orange, N.J., in which a former member of the medical staff charged hospital trustees with slander and conspiracy to defame him, when he was not recommended for reappointment to the staff two years ago.

When he was not reappointed, the physician, Dr. Louis F. Raymond, brought suit for damages against the president of the hospital, the president of its medical staff, the chairman of the joint conference committee, and members of the board of trustees. The complaint also alleged a conspiracy to remove him from the staff and a violation of the hospital's by-laws.

The New Jersey Hospital Association entered the case as a friend of court, seeking to determine that deliberations and discussions of responsible hospital officials should be held privileged.

The Court ruled that there had been no libel or slander as charged, that no conspiracy or malice existed, and that the hospital's by-laws had not been violated, the association reported.

According to the ruling, the discussions must meet two conditions in order to remain privileged: The subject under discussion must be apropos to a duty of the participants, and there must be no malice in any statements made about an individual.

New Officers Named for Michigan Health Council

DETROIT. — William S. McNary, executive vice president of Michigan Blue Cross, has been named president-elect of the Michigan Health Council.

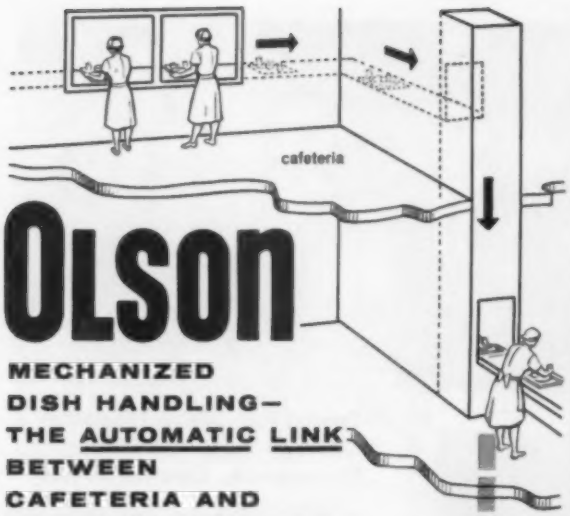
The Health Council represents more than 50 statewide health organizations and its objective is to study and help meet the health needs of all the communities in the state.

Other officials elected were: treasurer, L. Gordon Goodrich, executive vice president of Michigan Blue Shield; secretary, Hugh Brenneman, public relations counsel for the state medical society, and medical director, Dr. J. K. Altland, associate commissioner of the Michigan Health Department.

Opal J. Campbell To Head Oklahoma Accountants

OKLAHOMA CITY. — Opal J. Campbell, A.C.H. Hospital, Shawnee, was elected president of the Oklahoma chapter of the American Association of Hospital Accountants, at the organization's annual business meeting.

Other officers elected were: vice president, Ralph Stumpp, University Medical Center, Oklahoma City; secretary, Delores Lemmons, Mercy Hospital-Oklahoma City General, and treasurer, Riley Green, Valley View Hospital, Ada.



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Oklahoma Hospitals Elect New Association Officers

Officers elected at the Oklahoma Hospital Association's annual convention are, left to right: president-elect, Benny Carlisle, Oklahoma General Hospital, Clinton; president, A. M. Donnell, Muskogee General Hospital, Muskogee; secretary, C. L. Johnson, Grady Memorial Hospital, Chickasha, and treasurer, James Harvey, Hillcrest Medical Center, Oklahoma City. The convention was held in Oklahoma City with 867 attending.

Taxes Pay More Hospital Costs in New York Than Elsewhere, Council Finds

NEW YORK. — Tax funds and philanthropy pay for a larger portion of hospital care in New York City than is true in the rest of the country, the Hospital Council of Greater New York reports.

Tax funds assume more importance here, the council explained, because of the relatively greater role played by the municipal hospital system. Local government hospitals received 33 per cent of the total hospital dollar in New York compared with 21 per cent nationally.

The council found that of all the money spent for acute hospital care in New York City (not including that spent in federal hospitals), about 55 per cent comes from patients (or on their behalf from insurers), about 35 per cent from tax funds, about 7 per cent from philanthropy, and the remaining 3 per cent from miscellaneous sources. In contrast, for the country as a whole, private payments account for 81 per cent of hospital income; tax funds, only 14 per cent, and philanthropy, 5 per cent.

The council compared New York with 17 other large cities and found that it had the highest proportion of hospital income from tax funds and philanthropy in any of these cities and by far the lowest of private payments.

The report was based on one part of the hospital council's broad study of the relationships between the voluntary and municipal hospital systems in the city. In a forthcoming report of the complex study, to be published in the near future, the hospital council will recommend measures to modify the existing pattern of hospital financing, according to Dr. Hayden C. Nicholson, executive director of the council.

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Two Chapters Added to Accountants Association; First Officers Elected

CHICAGO. — Two new chapters have been added to the American Association of Hospital Accountants. The new chapters are the Colorado-Wyoming Chapter and the Ak-Sar-Ben Chapter, which includes the state of Nebraska. This brings the total of A.A.H.A. chapters to 61, according to Robert M. Shelton, executive director of the A.A.H.A.

Officers of the Ak-Sar-Ben Chapter are: Everett E. Graff, Nebraska Methodist Hospital, Omaha, president; E. C. Bowerman, Bishop Clarkson Hospital, Omaha, vice president; Richard L. Drozda, Lincoln General Hospital, Lincoln, secretary, and James O. Leslie, Bryan Memorial Hospital, Lincoln, treasurer.

Officers of the Colorado-Wyoming Chapter are: Sister Michael Marie, St. Joseph's Hospital, Denver, president; Harold Engle, Memorial Hospital, Casper, Wyo., president-elect; W. A. Michela, Community Hospital, Boulder, Colo., secretary, and Luke Birkey, Mennonite Hospital, La Junta, Colo., treasurer.

Ancillary Nursing Corps Proposed to Army

NEW YORK. — An expanded army nurse corps that would include ancillary nursing personnel was proposed here as a partial solution to "the shortage of nursing service in this country" by Dr. Catherine Worthingham, director of professional education for the National Foundation.

The program would utilize personnel presently ineligible for commission, such as practical nurses, graduates of two-year associate degree programs, and graduates from nonaccredited three-year nursing schools, in a hospital nursing corps that would be an autonomous division of the armed forces.

In recommending the formation of such a corp to the Defense Advisory Committee on Women in the Service, Dr. Worthingham emphasized that it "would provide an organizational structure that would make possible the development of 'reserve' organizations that would not threaten the very foundations of civilian institutions if a national emergency should develop."

18.7 per Cent Increase Asked by Michigan Plans

DETROIT. — Higher hospital costs and greater use of needed services by members were given as the reasons for a requested 18.7 per cent increase by Blue Cross-Blue Shield here.

The rate filings, calculated as the minimum needed to restore the plans to a sound financial position and retain it for at least two years, were announced by State Insurance Commissioner Frank Blackford. Also included were requests for several benefit improvements.

William S. McNary, executive vice president of Blue Cross, and L. G. Goodrich, executive vice president of Blue Shield, pointed out that both plans operated at a loss during 1960 and that outgo will exceed income at a greatly accelerated rate in 1961 until a rate adjustment can become effective.

These Sisters *Are* Sisters

These hospitals sisters *are* sisters. From the same family as well as the same nursing order, these hospital executives are pictured at the annual meeting of the Missouri Hospital Association. Left to right: Sister Mary Joan, Mount Alverno Convent, Maryville, Mo.; Sister Mary Anthony, record librarian at St. Elizabeth's Hospital, Hannibal, and Sister Mary Ursula, administrator of St. Francis Hospital, Maryville.

Southeastern Pharmacists Elect H. Clem President

MEMPHIS, TENN. — Howard Clem, Langdale, Ala., is the new president-elect of the Southeastern Society of Hospital Pharmacists. Vice president-elect is Owen L. Crutcher, Johnson City, Tenn. Newly elected officers will take office in April.

Apparent Rise in Infection May Reflect Other Factors, A.M.A. Report Indicates

CHICAGO. — The apparent increase in the rate of postoperative infection may be just that — apparent, rather than real.

This was one finding suggested in a *Journal of the American Medical Association* report on a study of the rate of infection following 3089 operations for removal of part of the stomach. The operations were performed at Massachusetts General Hospital, Boston, from 1932 through 1958.

The study showed a 16 per cent incidence from 1932 through 1940, 4.1 per cent from 1941 through 1953, and 9.4 per cent from 1954 through 1958.

The increase in the latter five-year period is largely the consequence of a greater incidence of infection in the general hospital service, the *Journal* article said. In the same period, the incidence of infection in the private service was only 5.5 per cent.

The increase in infection in the general hospital service also reflected a rise in the number of emergency subtotal gastrectomies performed, the article said.

Commenting on the study, the *Journal* said: "If future studies from other institutions are in accord with these facts, it may be concluded that any rise in the risk of postoperative surgical sepsis is more apparent than real and that such impressions are based on the treatment of more debilitated patients by a greater variety of complex technical procedures."

Dr. Paul Gross Named To Head A.A.A.S. in 1962

NEW YORK. — Dr. Paul Gross was named president-elect of the American Association for the Advancement of Science at the association's recent meeting held here. Dr. Gross, William Howell Pegram Professor of Chemistry at Duke University, will succeed 1961 president, Thomas Park of the University of Chicago.

A nationally known leader in scientific affairs, Dr. Gross is currently vice chairman of the National Science Board. He has been president of the Oak Ridge Institute of Nuclear Studies since 1949.

Hilliard, Lumpkin To Head Georgia Regional Councils

ATLANTA. — Oscar S. Hilliard, John L. Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, Ga., has been elected president of the Georgia Northwest Hospital Council.

Other officers of the Northwest Council are: Robert H. Jones, vice president, John L. Hutcheson Memorial Tri-County Hospital, and secretary-treasurer, Ruth Robertson, Villa Rica City Hospital, Villa Rica.

Joe A. Lumpkin, Douglas-Coffee County Hospital, Douglas, has been elected president of the Georgia Southeast Hospital Council. The Southeast Council also elected Henry J. McCormack, Bulloch County Hospital, Statesboro, vice president, and Elmer H. Clarke Jr., Emanuel County Hospital, Swainsboro, secretary-treasurer.

Pan Americans, U.S.P.H.S. Sign Research Agreement

BETHESDA, MD. — The U.S. Public Health Service has agreed to work cooperatively with the Pan American Health Organization in administering the medical research activities in the Americas.

The agreement was announced in a "statement of arrangements" issued jointly by both groups.

The agreement covers three points: (1) staff collaboration between P.A.H.O. and the U.S.P.H.S., (2) development of P.A.H.O. research activities, and (3) defining U.S.P.H.S. methods that might be applied to P.A.H.O. research activities.

Administrative Program Offered by Sloan Institute

ITHACA, N.Y. — The Sloan Institute of Hospital Administration at Cornell University will offer its fourth annual Hospital Administrators Development Program, to be held for four weeks, from June 25 to July 21.

The program is an intensive course of lectures, readings and discussions for hospital administrators, and is limited to approximately 25 administrators.

Application details may be obtained by writing to the Hospital Administrators Development Program, Sloan Institute of Hospital Administration, Rand Hall, Cornell University, Ithaca, N.Y.

Hospitals Can't Afford To Be Poor Employers, Institute Speaker Says

ANN ARBOR, MICH. — The public won't accept any excuse for hospitals being poor employers, hospital administrators at the University of Michigan's annual institute were told here recently.

Richard D. Vanderwarker, general manager of Memorial Center for Cancer and Allied Diseases, New York, whose hospital was one of seven institutions struck by unions last year, made that observation.

Recommending that hospitals voluntarily adopt the federal minimum hourly wage for all employes, he said: "We've got to be good employers. We must raise ourselves by our bootstraps to get the financial help we need for this purpose."

An official of the Building Services Employes International Union told the administrators that making needed improvements in personnel practices does not alone solve the problem of giving hospital workers a fair deal.

Anthony Weinlein, research director of B.S.E.I.U., also stressed that hospital administrators themselves should recognize the relative lowness of wages paid their employes. He also recommended that administrators acquire some knowledge of labor's history, of labor law and the practices that result from it, and of the structure of organized labor.

George Odiorne, director of the University of Michigan Bureau of Industrial Relations, told the institute that: "Collective bargaining, whether successful or not, undoubtedly affects wages upward, forcing administrators to improve the efficiency with which people are used."

In fact, he noted, hospital administrators may actually cut labor costs by raising individual wages and getting better employe performance.

"The difference between the worst employe and the best employe is a matter of 15 per cent in actual pay," he explained. "Yet the best employe will produce twice as much (or cost half as much) as the worst employe. By paying 30 to 40 per cent below the market, you buy iron-clad insurance of obtaining the worst available workers."

On the positive side, he noted, hospitals should increase their efforts to count fringe benefits in the salaries they give employes.

Philanthropy Is Expected To Set Record in 1961

NEW YORK. — Philanthropic giving will set a record in 1961, if it follows the trend of the last 10 years, according to a fund raising consultant.

Gifts are expected to increase at least $390 million over the 1960 record of $8 billion, estimates Charles A. Anger, chairman of the board of John Price Jones Company Inc., fund raising consultants here. The 1960 figure represents a 95.1 per cent increase over the 1950 total of $4.1 billion.

Gifts to health and welfare organizations showed the largest increases over the 10 year period, *i.e.* 327.8 per cent. In 1960, gifts for these causes were approximately $2.4 billion.

Individual contributions accounted for 77.5 per cent of the 1960 total, or an estimated $6.2 billion, according to Mr. Anger.

Summer Statistics Program Offered at U. of Minnesota

MINNEAPOLIS. — The fourth graduate program of statistics in the health sciences will be held this summer, from June 13 to July 28, at the University of Minnesota.

Course work will be in elementary or advanced statistics, vital records, records management, design of experiments, bioassay, sampling, demography and statistical aspects of nutrition research, genetics, pharmacology and mathematical models.

Stipends are available to qualified students, the university announced. Further information may be obtained by writing to: Biostatistics, 1226 Mayo, University of Minnesota, Minneapolis.

Arizona Association Elects M. G. Wolfers President

PHOENIX, ARIZ. — M. G. Wolfers was elected president of the Arizona Hospital Association at its 1960 convention. Mr. Wolfers succeeds Sister Elizabeth Joseph, St. Joseph's Hospital, Tucson, who was elected to a three-year term as trustee.

Others elected include: vice president, A. H. Dysterheft, McNary Hospital, McNary, and secretary-treasurer, Roland Wilpitz, Marcus J. Lawrence Memorial Hospital, Cottonwood.

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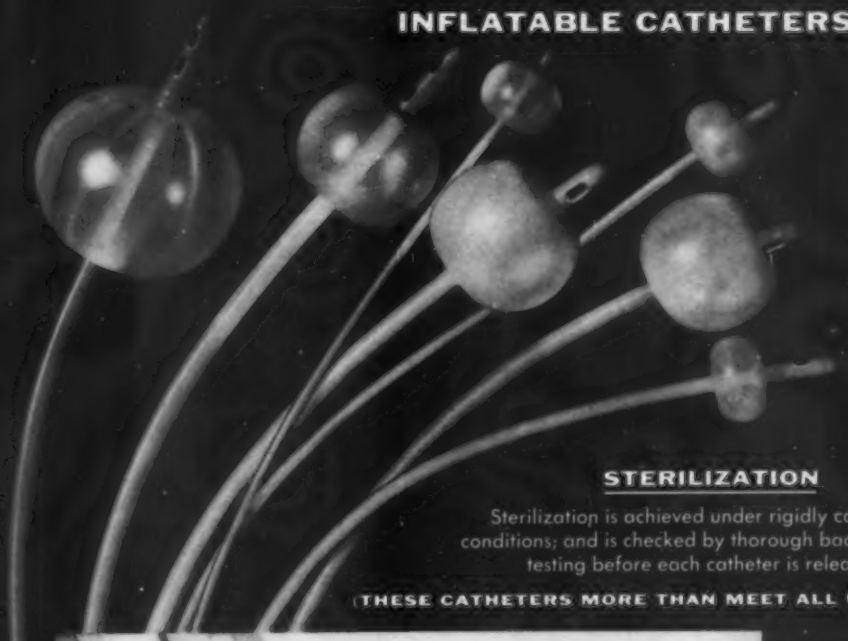

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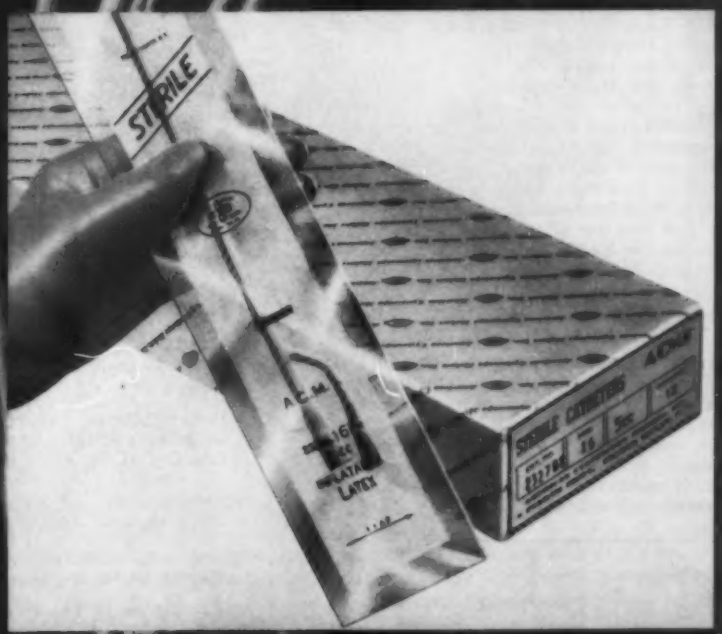

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COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF SURGEONS, Sectional Meeting, Philadelphia, March 6-9.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

ASSOCIATION OF UNIVERSITY PROGRAMS IN HOSPITAL ADMINISTRATION, Brooke Army Medical Center, Fort Sam Houston, San Antonio, Tex., May 4, 5.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 14-17.

CAROLINA'S-VIRGINIA HOSPITAL CONFERENCE, Roanoke, Va., April 13, 14.

CATHOLIC HOSPITAL ASSOCIATION, Civic Auditorium, Detroit, June 12-15.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin, June 14.

COMITE DES HOPITAUX DU QUEBEC, Montreal Show Mart Inc., Montreal, Que., June 26-28.

GEORGIA HOSPITAL ASSOCIATION, Biltmore Hotel, Atlanta, March 23, 24.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Atlantic City, May 17-19.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 5.

IOWA HOSPITAL ASSOCIATION, Fort Des Moines Hotel, Des Moines, April 26, 27.

KENTUCKY HOSPITAL ASSOCIATION, Lexington, March 21-23.

LOUISIANA HOSPITAL ASSOCIATION, Captain Shreve Hotel, Shreveport, Feb. 23-25.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 6, 7.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler Hilton, Boston, May 11.

MICHIGAN HOSPITAL ASSOCIATION, Hotel Pantlind, Grand Rapids, June 18-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 17-19.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 26-28.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION AND SERVICE, Statler-Hilton Hotel, Detroit, April 24-28.

NATIONAL LEAGUE FOR NURSING, Public Auditorium, Cleveland, April 10-14.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 20-22.

NEW HAMPSHIRE HOSPITAL ASSOCIATION, Wentworth-by-the-Sea, Newcastle, June 1, 2.

NEW MEXICO HOSPITAL ASSOCIATION, Albuquerque, May 17-19.

OHIO HOSPITAL ASSOCIATION, Veterans Memorial Bldg., Columbus, April 3-6.

QUEBEC HOSPITAL ASSOCIATION, Queen Elizabeth Hotel, Montreal, April 19-21.

SOUTH DAKOTA ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Rapid City, Oct. 25, 26.

SOUTHEASTERN HOSPITAL CONFERENCE, Memphis, April 19-21.

TENNESSEE HOSPITAL ASSOCIATION, Riverside Hotel, Gatlinburg, May 25, 26.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton, Dallas, May 14-17.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UPPER MIDWEST HOSPITAL CONFERENCE, St. Paul, May 10-12.

WISCONSIN HOSPITAL ASSOCIATION, Schroeder Hotel, Milwaukee, March 16.

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Water treated to be colorless, odorless, tasteless; then carbonated. *Sugar* that meets standards more rigid than those for table sugar. *Citric acid*, the natural acid present in citrus fruits. *Sodium citrate* to help develop the fresh, clean taste of 7-Up. *Natural oils* pressed from fresh lemon and lime peel, and super-refined to select and concentrate only the most desirable parts of their pure, natural flavors.

Seven-Up is exactly what our "second label" says it is . . . finest quality which you may recommend with confidence.

Nothing does it like Seven-Up!

ABOUT PEOPLE

(*Continued From Page* 116)

Sister M. Celine has succeeded **Sister M. Borroemea** as administrator of St. Francis Hospital, Escanaba, Mich. Sister Borroemea has been assigned as first assistant to the Sister Superior at the Order's St. Joseph Hospital, Keokuk, Iowa.

Maurice P. Coffee Jr. is the new associate director of Jefferson Medical College Hospital, Philadelphia. He was previously assistant administrator at Shadyside Hospital, Pittsburgh. Mr. Coffee holds a bachelor's degree in hotel management from Pennsylvania State University, and a master's degree in hospital administration from Northwestern University.

Robert A. Cunningham, assistant administrator of Port Huron Hospital, Port Huron, Mich., has accepted the position of administrator of Lakeland Memorial Hospital, Woodruff, Wis.

Robert D. Stout has become administrator of Putnam Memorial Hospital, Bennington, Vt. Mr. Stout was formerly assistant administrator of Ellis Hospital, Schenectady, N.Y. He is a graduate of West Virginia University and holds a master's degree from Columbia University.

Robert F. Peck has been named administrator of Lutheran Hospital, Sioux Center, Iowa. He succeeds **Fred A. Molgren,** who resigned. Mr. Peck has a master's degree in hospital administration from Washington University, St. Louis.

Sandy Anderson, formerly administrative assistant at Grady Memorial Hospital, Atlanta, Ga., has accepted the position of administrator, Tallassee Community Hospital, Tallassee, Ala.

Andrew H. Mettee has been named administrator and business manager, Nevada State Hospital, Reno. Mr. Mettee has been administrator of White Pine General Hospital, Ely, Nev., for the last four years. He completed the course in hospital administration, continuation education, School of Public Health and Administrative Medicine, Columbia University.

Otis L. Clasby has resigned as superintendent of Thayer Memorial Hospital, Hebron, Neb., to accept a similar position at Morehouse Memorial Hospital, Benkelman, Neb. **Wilma Bice** will assume executive duties at Thayer until a new superintendent is named.

Guy Cromwell has been appointed administrator of Martin Memorial Hospital, Stuart, Fla. He was previously hospital consultant to the Florida Development Commission. **Harold Wetzel** has been named to succeed Mr. Cromwell on the commission. Mr. Wetzel previously was administrator of Miners' Hospital of Northern Cambria, Spangler, Pa.

Duane T. Houtz, administrative assistant at Orange Memorial Hospital, Orlando, Fla., has been appointed assistant director of the University of Florida Hospital and Clinics, Gainesville.

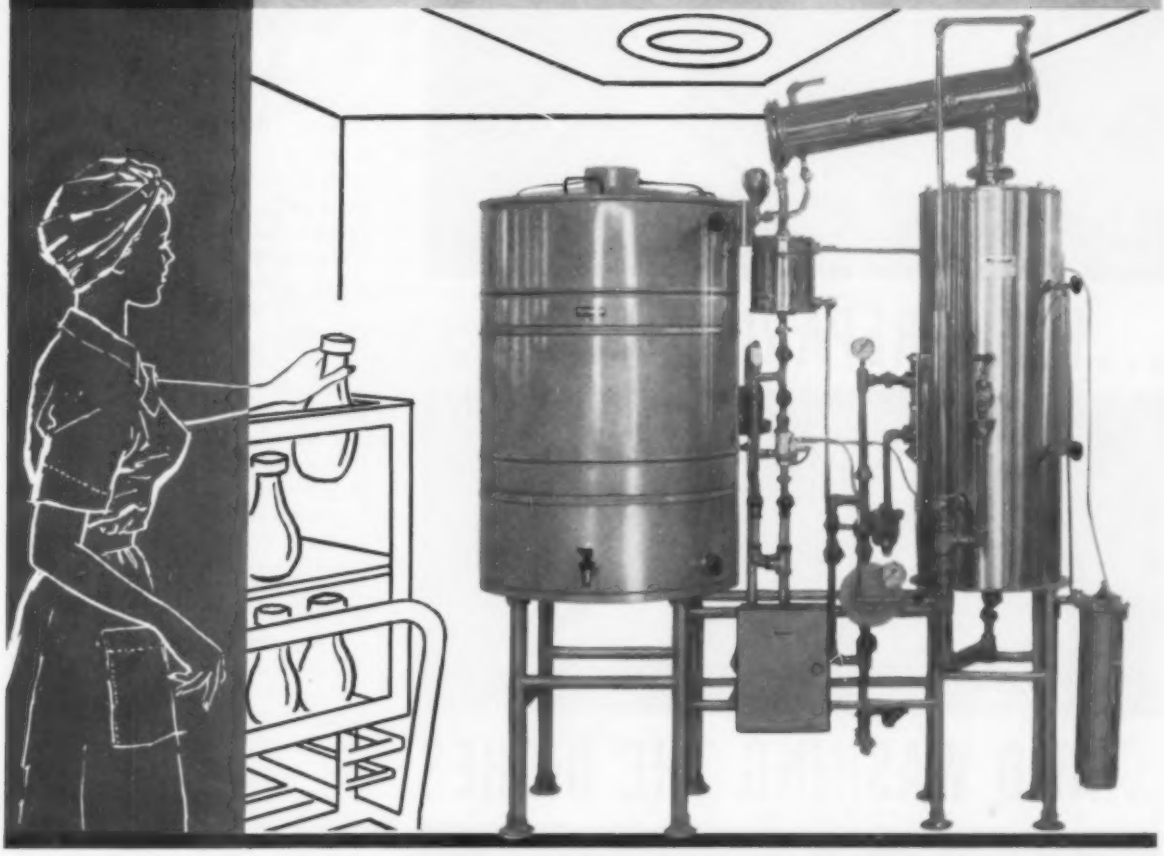
J. B. Storrs is now the manager of American Fork Hospital, American Fork, Utah.

O. D. Niswonger has been named assistant administrator at Southeast Missouri Hospital, Cape Girardeau, Mo. Mr. Niswonger was formerly consultant for the Missouri Heart Association. He has a master's degree in public health from the University of North Carolina.

M. F. Cantile has been named administrator of Ridgecrest Hospital,

(*Continued on Page* 188)

new better way to produce and store distilled water *by* Barnstead



4-way purification
never needs cleaning

NEW FEEDBACK PURIFIER STILLS . . . combine condensation, ion exchange, organic removal and distillation to produce higher purity water than *any other single Still.* Boiler steam is first used for heating the evaporator water. Then it is cooled and passed through an ion exchange column. Here scale forming hardness is removed so that it cannot collect on evaporator walls or steam coil. Boiler treatment amines are also removed by ion exchange up to concentrations of 3 ppm. Next, condensate passes through an organic removal column which takes out oil droplets and objectionable odors. Pretreated condensate then enters evaporator as feedwater. This extremely efficient system is inexpensive to operate since each pair of cartridges lasts several months.

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No valuable time taken to clean Still and pyrex bottles because *scale can't form* on evaporator walls or coil. Still stays in service for months without maintenance even in hardest water areas. Hospitals report that even after 16 months' continuous service the Still required no cleaning.

higher purity distillate
completely automatic

HIGHER PYROGEN FREE PURITY

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FULLY AUTOMATIC CONTROLS

Controls automatically start Still when water in storage tank drops to a predetermined level, stop Still when tank is full again. As long as the Level Monitor on the storage tank calls for water, the Still continues to operate. Thus, your distilled water supply is replenished during non-use hours without supervision and a full tank of pure distilled water is available to begin each day's operation.

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Barnstead Ultra-Violet equipment (a) protects distilled water against bacteria for at least 30 days and (b) kills bacteria introduced into tank. The Barnstead Ventgard filters out all airborne impurities down to 0.2 micron . . . and removes all types of bacteria and particles as well as carbon dioxide and other gases.

purity protected in storage
greater storage capacity

DISTILLED WATER ALWAYS ON TAP

New Barnstead fully automatic Still continuously replenishes pure water supply 24 hours a day without attention. Even though distilled water supply is depleted at day's end, the storage tank is filled again automatically before the beginning of the next day with sterile, pyrogen free distilled water. Thus hospitals have ample supply of distilled water even during peak use periods.

Write for Bulletin #162 describing Barnstead's new and better way to produce and store distilled water.

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(*Continued From Page* 186)

Ridgecrest, Calif. Previously, he was administrator of Woodruff Community Hospital, Long Beach, Calif.

Merlin Traylor is the new administrator of Memorial Hospital, Odessa, Wash.

Marion R. Bowman has assumed the position of superintendent at Roosevelt Latter Day Saints Hospital, Roosevelt, Utah.

DeWitt Brown has resigned as controller of Baptist Memorial Hospital, Jacksonville, Fla., to become assistant administrator at the Baptist Memorial Hospital, Kansas City, Mo.

Gareth Mitchell, administrative assistant at Baptist Hospital, Memphis, Tenn., has resigned to accept the post of assistant administrator of University Hospitals, Cleveland.

J. L. Reveley has been named assistant administrator in charge of general services at Peninsula Hospital, Burlingame, Calif. Mr. Reveley is a graduate of the University of California course in hospital administration. He served his administrative internship at Santa Barbara Cottage Hospital, Santa Barbara, Calif., and his residency at Peninsula Hospital. At the same time it was announced that **Ronald W. Carson** has been appointed assistant administrator in charge of administrative services at Peninsula Hospital. Mr. Carson is a graduate of the University of California course in hospital administration. He served his administrative internship at Alta Bates Hospital, Berkeley, Calif., and his residency at Virginia Mason Hospital and Mason Clinic, Seattle.

Walter F. Slee has been named an assistant director of Akron General Hospital, Akron, Ohio. Mr. Slee has been controller of the hospital since 1958, and will continue in that capacity along with his new responsibilities. Mr. Slee is a member of the National Association of Accountants, National Office Management Association, and the American Association of Hospital Accountants.

Raymond L. Ingraham has been appointed administrator of Winter Park Memorial Hospital, Winter Park, Fla. Mr. Ingraham served in the administrative division of the North Carolina Memorial Hospital, University of North Carolina, Chapel Hill, for five years. For the last four years he has been administrative assistant at Winter Park.

Helen Richardson has accepted the

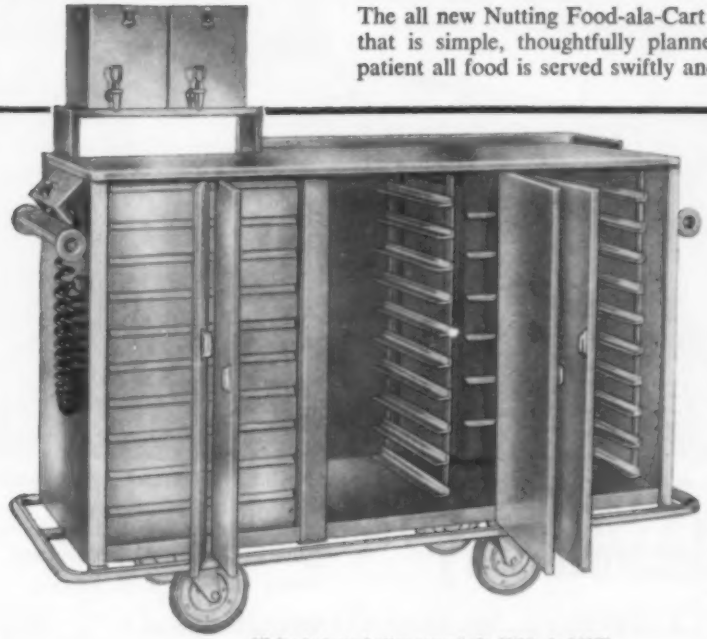
(*Continued on Page* 190)

new idea streamlines
hospital food service

Nutting FOOD-ala-CART System

ends "DIET TRAY CONFUSION!"

The all new Nutting Food-ala-Cart gives your hospital a food service system that is simple, thoughtfully planned and easy to follow. From kitchen to patient all food is served swiftly and more easily with Food-ala-Cart.

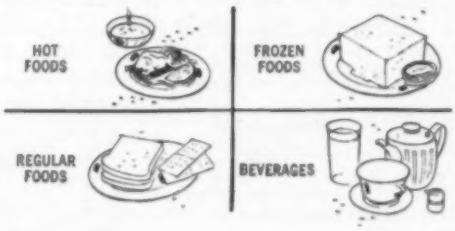


Food-ala-Cart ends diet tray confusion because there is only **one** serving per oven drawer and this matches its own serving tray . . . there's absolutely **no chance** of mix-up or confusion!

Food-ala-Cart also improves the appetite appeal of food because it has three separate temperature zones ranging from "piping hot" to "cold" to "deep freeze." All foods reach patients at the peak of flavor and nutrition and at dietetically approved serving temperatures.

Your hospital food service system will function more smoothly with Nutting Food-ala-Cart on the job. This equipment is the "key" that unlocks the door to well-balanced food service and makes everyone, from the dietitian to the patient to the physician, happier and more satisfied with food preparation and service. Write today for complete facts about this newest idea to streamline your hospital food service.

All foods taste better served via FOOD-ala-CART!



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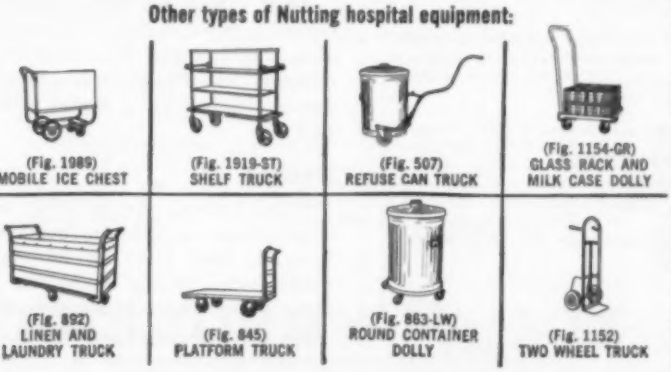

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City_____ State_____

(*Continued From Page* 188)
position of administrator of St. Helen's Hospital, Bellflower, Calif.

Larry C. Lomax, administrator of Sierra Madre Medical Center and Sierra Madre Hospital, Sierra Madre, Calif., has resigned. **Dr. George W. Groth,** owner of the facilities, will take over administrative duties.

Department Heads

James J. Catania has been appointed director of nurses at Chester Hospital, Chester, Pa. Mr. Catania was a former supervisor at the Institute of Pennsylvania Hospital, Philadelphia.

Margaret Cere has been named dietitian at Veterans Administration hospital, Salt Lake City. She was formerly nutritionist for the Dairy Council of Utah.

Mary Connolly has been named director of nursing at Memorial Hospital for Cancer and Allied Diseases, New York. Miss Connolly has been assistant director of nursing since 1944.

Dr. Anita Isaac has been named chief of the physical medicine and rehabilitation service for Wichita-St. Joseph Hospital, Wichita, Kan.

Sister Alice Marie has been appointed director of dietary services at Hotel Dieu Sisters' Hospital, New Orleans.

Dr. Charles M. Sloan has been named director of the anesthesia department of Methist Hospital of Dallas. Dr. Sloan is a graduate of Southwestern Medical School and has been a member of the staff of Methodist Hospital of Dallas since 1956.

Dr. C. M. Sloan

Louis Swatzburg has accepted the position of controller of Prospect Heights Hospital, Brooklyn, N.Y. Mr. Swatzburg previously held the same position at Pontiac General Hospital, Pontiac, Mich. He has also held similar positions at Sinai Hospital, Detroit, and the Hospital for Joint Diseases, New York.

Bernard Christopher is the new chief pharmacist at Passavant Memorial Hospital, Chicago, succeeding **Harry Rice,** who died recently. **Marylin Ivanick** has been appointed assistant chief pharmacist.

Armand Jaquier has been appointed director of building services at Jewish Hospital of St. Louis.

Miscellaneous

Dr. James H. Matthews, assistant chief of pulmonary disease service at the Oteen, N.C., Veterans Administration hospital, has been appointed chief of the V.A. clinical research in pulmonary diseases.

David W. Stickney, administrative assistant of Children's Memorial Hospital, Chicago, has been named assistant director of the Illinois Hospital Association.

Floyd Parrish has been appointed special assistant to the Commissioner of Mental Health for the state of Connecticut. Mr. Parrish was formerly director, Sailors Snug Harbor, New York.

Deaths

Mabel Davies, superintendent and administrator of Beekman-Downtown Hospital, New York, for 30 years, died recently. During World War II, Miss Davies helped organize and equip the army, navy and Red Cross nursing units.

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By using Pittsburgh Color Dynamics, many hospitals have improved efficiency of medical and nursing staffs, at the same time providing greater comfort for patients.

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• **Proper colors at nurses' stations** have helped to enhance alertness and efficiency. Morale and comfort of resident staffs have been improved by colors that make living quarters more pleasing and cheerful.

• **By the use of Color Dynamics** patients' rooms have been color-planned to make them more comfortable and restful, thus frequently speeding convalescence and recovery. Soothing and relaxing colors in delivery rooms help to ease the pangs of labor.

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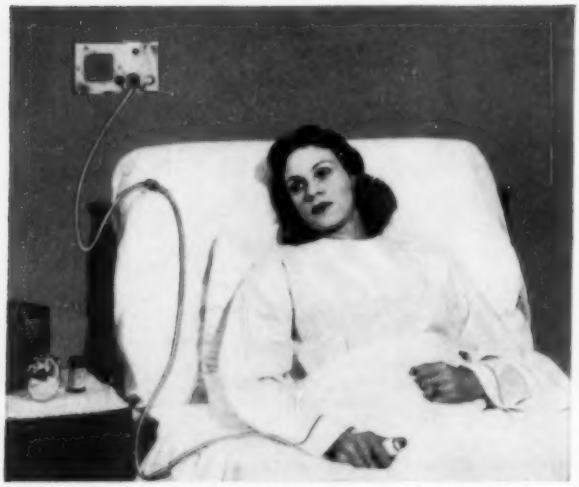
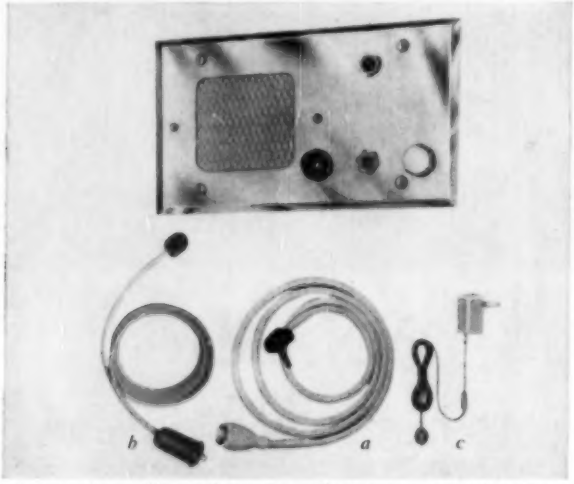


▲ *The patient may talk to the nurse—even whisper—from any position in her bed.*

▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for calls from: a. normal patients; b. patients who cannot speak or hear; c. oxygen-tent patients.*

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Statistics show that a modern nurses' calling system, properly installed and properly used in your hospital, will greatly increase the nurses' effectiveness through saved footsteps, ability to take care of more patients, greater concentration on direct bedside care, and increased morale and feeling of accomplishment. This offers the tremendous benefits to the hospital of greater staff efficiency and service, reduced operating costs, more and speedier recoveries, and increased goodwill.

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ANESTHETIST—Fully accredited, AANA, Certified, experienced female, capable of administrator-anesthetist position thru experience; experienced in all agents and techniques; neurosurgery, thoracic and cardiac surgery; pediatric and general surgery, obstetric; experienced and qualified; prefer Hawaii or southern state location. Reply MW 96, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

CONTROLLER—Ten years hospital experience as controller and assistant administrator; B.S. major in Accounting; Fellow — AAHA. Address MW 92, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

EXECUTIVE HOUSEKEEPER—Experienced in hospitals and hotels; top management; opened new hospitals; 300-bed limit; excellent references; prefer southern California. Apply MW 88, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago, Illinois.

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ANESTHESIOLOGIST — American Board Diplomate; assistant chief department anesthesia; 300-bed hospital, six years; 36 years of age.

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ASSISTANT ADMINISTRATORS—(a) 35; 6 years PT, 100-bd child's hospital; 4 years assistant administrator 500-bed university unit; seeks better post; NACHA. (b) 45; RN; BS; 12 years administrative experience, 700-bed unit; only near university centers. (c) 32; BS; MPH; AHA; 1 year resident, 325-bed unit; 1 year administrator 50-bed unit. (d) 27; BBA; MSHA; AHA; resident at 450-bed unit; available June '61. (e) 28; BA; MHA; AHA; resident university unit; 3 years administrator for a 50-bed hospital prefers east.

ADMINISTRATIVE ASSISTANT—(f) 25; BA; MSHA; 1 year resident and 1 year administrative assistant, 225-bed unit. (g) 26; BA; MSHA; resident at 500-bed university unit; 2 years with City hospital control as administrator 50-bed unit.

ANESTHESIOLOGY—36; Board eligible; now assistant professor of anesthesia at a medical school, and attending at 2 large hospitals; seeks directorship, prefers with teaching, anesthesiology.

PATHOLOGY—32; Certified, both branches; 2 years associate pathologist 275-bed unit; seeks to direct department.

RADIOLOGIST—35; Diplomate, diagnostic & therapeutic; 5 years associate radiologist, 500-bed unit; seeks chiefship.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director

332 Bulkley Building

Cleveland 15, Ohio

ADMINISTRATIVE ASSISTANT—Age: 34 years; B.B.A. Degree, 1960; 5 years experience, business manager active medical center; available.

PURCHASING AGENT—Age: 40 years; 10 years assistant purchasing agent; 150-bed hospital; desires situation in medium-size southern institution.

ADMINISTRATOR — M.H.A. Degree; 4 years assistant administrator, large teaching hospital; east; outstanding references.

INTERSTATE—*Continued*

R.N. ADMINISTRATOR—M.A.C.H.A.; age: 50 years; 20 years experience; past seven years superintendent, 110 bed eastern hospital.

COMPTROLLER—B.S. Degree, Accounting; 12 years experience with accounting firm; 4 years consultant work, medium-size hospital.

EXECUTIVE HOUSEKEEPER—Age: 51 years; courses in institutional housekeeping; 12 years experience western hospital, 300-beds.

POSITIONS OPEN

ADMINISTRATOR—Assistant; recent course graduate with some hospital experience. Apply Mr. Donald E. Gilbert, Administrator, BROCKTON HOSPITAL, 680 Centre Street, Brockton, Massachusetts.

ASSISTANT HOSPITAL ADMINISTRATOR—Can you face a challenge? If so, and you are a college graduate with a master's degree in hospital administration, we invite you to apply for this desirable position in our large modern institutional set up; $640 to $758 per month plus job security, advancement opportunity and sound retirement system including social security; liberal paid holiday, vacation, medical and life insurance and sick allowance. Formal application must be on file by 4 PM March 2, 1961. MILWAUKEE COUNTY CIVIL SERVICE COMMISSION, Room 206, Courthouse, Milwaukee 3, Wisconsin.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—Nurse; starting salary $550.00 per month; new and modern building and presently enlarging; interview necessary. Apply CHILDRESS CLINIC AND HOSPITAL, Box 867, Goldthwaite, Texas. Telephone MI 8-2212.

ANESTHETIST—Registered; male or female, fully accredited modern 150-bed hospital, department directed by chief of surgery; starting salary $600 plus 2 weeks vacation, health insurance, sick leave, social security and group life insurance, paid educational leave. Apply to Homer E. Allen, Administrator, CLINCH VALLEY CLINIC HOSPITAL, Richlands, Virginia.

ANESTHETIST—Nurse; for 45-bed active County hospital, Page County, Virginia; salary open. Write Dr. Walter E. Schlabach, 14 S. Court Street, Luray, Virginia or PAGE COUNTY MEMORIAL HOSPITAL.

DIETITIAN—150-bed general hospital, located in southern California smog free area; salary open. Reply to MO 327, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Eligible for American Dietetic Association; salary $410-492; located 50 miles north of San Francisco near the Russian river. Apply SONOMA COUNTY CIVIL SERVICE COMMISSION, 2555 Mendocino Avenue, Santa Rosa, California.

DIETITIAN—135-bed general hospital; near resorts, good personnel policies and salary. Apply Administrator, MILFORD MEMORIAL HOSPITAL, Milford, Delaware.

(Continued on page 194)

classified advertising

POSITIONS OPEN

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries being at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Mrs. Alice Beech, Personnel Director, AKRON CITY HOSPITAL, 525 E. Market Street, Akron, Ohio.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 week vacation; also: Assistant dietitian; salary open, 2 week vacation, 2 meals and laundry furnished; 40 hour week, 6 holidays; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—A.D.A.: therapeutic and teaching; 485-bed general private hospital with school of nursing; good salary, opportunity for advancement. Apply Director of Dietetics, YOUNGSTOWN HOSPITAL, North Unit, Youngstown, Ohio.

DIETITIAN—A.D.A.: tray service supervision and patient contact; 485-bed general private hospital; good salary opportunity for advancement. Apply Director of Dietetics, YOUNGSTOWN HOSPITAL, North Unit, Youngstown, Ohio.

DIETITIAN—Therapeutic; 500-bed hospital. Apply to Miss Helen M. Druley, Director of Food Service, HARRISBURG POLYCLINIC HOSPITAL, Harrisburg, Pennsylvania.

DIETITIAN—Needed for 93-bed JCAH approved general hospital located on South Atlantic Coast; prefer ADA member with hospital experience; good personnel policies; salary open. Send resume, including references, experience, date available, and salary desired in first letter. Apply Miss Ruth M. Puehler, Administrator, GEORGETOWN COUNTY MEMORIAL HOSPITAL, Georgetown, South Carolina.

DIETITIANS—see page 200 also

DIRECTOR OF MEDICAL RECORDS—The METHODIST HOSPITAL, Texas Medical Center, Houston 25, Texas; hospital currently at 370-beds with expansion to 700-beds in progress; general, acute, teaching hospital with medical school affiliation; considerable experience necessary; salary open. Write Glenn Lanier, Assistant Administrator.

DIRECTOR—Public Health Laboratory; three years of responsible professional experience in a medical or public health laboratory; Ph.D. major in bacteriology or any equivalent combination of experience and training; salary open. Write Arthur S. Taylor, Personnel Officer, Health and Welfare Department, State House, Augusta, Maine.

DIRECTOR OF NURSING—For a 180-bed hospital located in southern New England; must have Master's Degree and be capable of directing nursing school and service; salary $7,500 up, dependent upon experience; excellent fringe benefits; willing to consider persons with limited experience who have potential; please provide full details in first letter. Apply MO 330, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—New 663-bed acute general and T.B. hospital; approved residency and intern training programs; house and visiting staff; no smog, snow, or sleet and low humidity contribute to enjoyment of year round outdoor living; adjacent to three national parks and Sierras; BS nursing program local college; cultural advantages and plentiful, moderately priced housing; salary $7980 — $9972; requires nursing degree, five years supervisory nursing experience, and eligibility for California license. Write or call Edward W. Firby, Director of Personnel, Room 101, Hall of Records, Fresno 21, California. AMherst 8-6011.

DIRECTOR OF NURSING—Modern general hospital, 202-beds; excellent equipment and facilities; JCAH accredited; community 14,000; 19 miles west of Sacramento, 85 miles north of San Francisco; salary commensurate with training and experience. Apply W. J. Blevins Jr., M.D., Medical Director, YOLO GENERAL HOSPITAL, Woodland, California.

(Continued on page 196)

Light-colored floor? Vinyl problem? Anti-slip requirement?

Super Flor-Treat is your answer

For a beautiful anti-slip floor finish that contains no wax, MULTI-CLEAN all-resin *Super Flor-Treat* is unexcelled.

It may be used on asphalt, rubber, or vinyl tile, linoleum, terrazzo, wood, or concrete, and is a real problem-solver in these situations:

For Light-Colored Floors. Water-white *Super Flor-Treat* dries to a light-colored finish that won't yellow the lightest of floors (even white ones)!

When Insurance Regulations prohibit use of wax, *Super Flor-Treat* gives an easy-to-clean, self polishing, glossy finish that will match the best waxes in every respect including *scuff-resistance, buffability,* and *ease of removing.* It is listed by U/L as an anti-slip material.

On Vinyl Tile, and other floors to which wax will not adhere satisfactorily, *Super Flor-Treat* may be applied without crawling or puddling. On such floors it is often used as a base for wax.

Faint But Pleasing Aroma makes it more pleasant to apply than sealers with objectionable odors.

Used as a base, *Super Flor-Treat* tends to restore color and brilliance to old, faded tile. Wax lasts longer when *Super Flor-Treat* is used as a base. Or, used alone, it gives a handsome, durable, highly water-resistant finish of which you can be proud.

Super Flor-Treat is just one of 27 modern cleaners, sealers, and finishes developed by MULTI-CLEAN Research. For more information on these materials and the scientific MULTI-CLEAN METHOD for maintaining your floors, call your local MULTI-CLEAN Distributor or write to Multi-Clean Products, Inc., Dept. MH-69-21, St. Paul 16, Minnesota.

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For additional information, use postcard facing back cover.

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POSITIONS OPEN

DIRECTOR OF NURSING EDUCATION—New school and residence facilities in planning stage; small school, good salary, colleges, nice little city. ASBURY HOSPITAL, Salina, Kansas.

DIRECTOR SCHOOL OF NURSING—Sixty year old diploma school with 160 students; 400-bed JCAH accredited community general hospital; new building program; salary open; for details write Erwin C. Pohlman, Administrator GRANT HOSPITAL, Columbus 15, Ohio.

INSTRUCTOR—Clinical; obstetric nursing; diploma program, 250-bed hospital, 120 students enrolled; B.S. degree required; salary commensurate with qualifications. Apply Director of Nursing, ARNOT-OGDEN MEMORIAL HOSPITAL, Elmira, New York.

INSTRUCTORS—Clinical; for new collegiate nursing program, to teach in the areas of medical-surgical, maternal and child care, psychiatric and public health nursing; Master's degree in nursing required; academic appointments and attractive personnel policies. Apply Dean, School of Nursing, EAST CAROLINA COLLEGE, Greenville, North Carolina.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

LIBRARIAN—Medical record registered; To supervise department of large teaching hospital in Chicago; salary commensurate with ability. Send resume with all particulars to MO 329, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical record; opening for chief librarian at City Hospital, a 1,000-bed general hospital; must be registered with American Association of Medical Record Librarians. Write for further information Department of Personnel, CITY OF ST. LOUIS, 235 Municipal Courts Building, St. Louis 3, Missouri.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

MISCELLANEOUS—PHYSICAL THERAPY CONSULTANT; Salary $487 - $589; (appointment may be made above entrance salary.) graduation from college and an approved school of physical therapy, and three years experience as a physical therapist; vacancy is in the STATE HEALTH DEPARTMENT.

DIETITIAN—Salary $487 - $589; (appointment may be made above entrance salary.) graduation from college and three years ex-

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POSITIONS OPEN

perience as an institutional dietitian; vacancy exists at the STATE MENTAL HOSPITAL, Sparks, Nevada.

REGISTERED NURSE—Salary $347 -$421; (appointment may be made above entrance salary.) graduation from an accredited three year school of nursing and registration as a registered nurse in the State of Nevada at the time of appointment; vacancy exists at the STATE MENTAL HOSPITAL, Sparks, Nevada; liberal fringe benefits including paid vacation leave, paid sick leave and merit salary increases; enjoy an ideal climate in which numerous recreational opportunities exist. Apply: STATE PERSONNEL DEPARTMENT, Heroes Memorial Building, Carson City, Nevada.

NURSES—General duty; for 75-bed hospital expanding to 200-beds; progressive patient care, physical rehabilitation and home nursing program being developed; salary $345.00 to $360.00 with differential for evening and night; opportunity to advance to charge and supervisory positions; hospital located northwest of large metropolitan area in Michigan; communicate with Director of Nurses, MCPHERSON COMMUNITY HEALTH CENTER, Howell, Michigan.

NURSES—Staff; for young residential facility for epileptic children with adjustment problems; required: R.N.; interest in therapy, research, and professional training programs; start at $4000 or higher. Write Personnel, NATIONAL CHILDREN'S REHABILITATION CENTER, Leesburg, Virginia.

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

PATHOLOGIST—Board Diplomate or eligible, for full time position; 127-bed general hospital; located adjacent to Boston; 1st phase of building program starting May 1961 will include complete up to date laboratory facilities, present facilities 1 year old. Apply Administrator, SOMERVILLE HOSPITAL, 30 Crocker Street, Somerville 43, Massachusetts.

SALES MANAGER—For hospital room furniture; exceptional opportunity for a man with strong background and proven experience in this field; top quality line; salary open. Submit detailed resume in strict confidence to MO 331, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERINTENDENT OF NURSES—Modern state mental hospital of 3400-beds; capable person for administrative responsibilities and leadership for nursing and psychiatric aides staff; affiliating nursing school; baccalaureate required, masters desirable; liberal personnel policies; living quarters available at nominal cost; starting salary $6474 to $8242; maximum reached in five years. Apply MO 317, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR—Operating room; position available in a 90-bed community hospital with expansion program in the offing; located within commuting distance of metropolitan areas in south eastern Michigan; general surgery; salary open and based on experience, education, etc.; sick leave, vacation, life insurance; regular increments for two years. Apply 324, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISING NURSE—Position open as inservice training supervisor in 135-bed comprehensive rehabilitation service which is expanding to 200-bed service with new construction in progress; requires B.S. degree in Nursing or Nursing Education and three years nursing experience including one year as a head nurse; salary $5,568-$6,972. Contact Mr. Einor Nordby, Manager, REHABILITATION CENTER, 1100 Polhemus Road, San Mateo, California.

SUPERVISOR — Obstetrical; for 600-bed modern general hospital completing large addition; fully approved accredited school of nursing; excellent salary, generous benefit program, 4 weeks vacation. Apply Personnel Director, CHRIST HOSPITAL, Cincinnati, Ohio.

THERAPIST—Physical; 52-bed general hospital, active outpatient department; new 60-bed hospital in planning stage; will consider recent graduate; above average starting salary and extra benefits; opportunity to help plan and work in completely new facility. Apply L. D. Feeback, Administrator, WARRENSBURG MEDICAL CENTER, 122 E. Market, Warrensburg, Missouri.

THERAPIST—Immediate opening for male OTR to head the activity therapy department in large state hospital; large department with emphasis on industrial activities; other sections within the department include occupational therapy, recreation, education, volunteer services and audio-visuals; hospital is growing with many new buildings and programs; liberal personnel policies; three years experience with one year supervisory level required; salary range from $5400 to $6720 per year. Write Theodore G. Denton, M.D., Superintendent, CENTRAL STATE HOSPITAL, Petersburg, Virginia.

ADMINISTRATORS—(a) Medical education co-ordinator; prefer an internist; 275-bed fully approved general hospital; to $15,000 and ample benefits; midwest. (b) MHA with excellent experience; direct 750-bed, medical school affiliated, fully-accredited hospital; large city, excellent salary; east. (c) Administer a 300-bed fully approved general hospital; $12-$15,000; town of 25,000; southeast. (d) Male or female with 5 years administration experience; new 130-bed JCAH general hospital; minimum $10,000; mideast. (e) 50-bed short term general; $6000; west. (f) Assistant administrator; 900-bed university medical center; excellent salary and opportunity; southwest. (g) Assistant, with degree and experience; 350-bed fully accredited; about $8000; midwest. (h) Assistant, experienced with degree; new post; 275-bed fully approved; $7500 to $10,000; near the nation's capital. (i) Assistant, 125-bed hospital with active expansion program, $7800; California.

EXECUTIVE POSTS—(j) Clinic manager; 50 Board men, nationally recognized; southwest. (k) Comptroller; 250-bed, general JCAH hospital; $8-9000; east. (l) personnel director, 500-bed general, full approved, medical school affiliated; about $7000; south. (m) Purchasing agent for 275-bed full-approved expanding hospital; salary open; east.

(Continued on page 198)

classified advertising

POSITIONS OPEN

The Medical Bureau
M. BURNIECE LARSON—DIRECTOR
Telephone DElaware 7-1050
900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) M.D. Administrator; 5 years experience large hospital, midwest; $23,000. (b) Administrator M.H.A. required; 800-bed voluntary general hospital, model midwestern city, 175,000; $15-$18,000. (c) Administrator; Florida resort area, hospital; $10-$14,000; (d) Administrator; 30-bed hospital in building process; 100 miles from Chicago; $7-8000. (e) Administrator; 60-bed hospital expanding to 100; start $8000; near university center, Iowa. (f) Assistant director leading western university hospital, 900-beds; $10,000 up. (g) Assistant administrator; 350-bed hospital university affiliated near Chicago, $8-$10,000.

ADMINISTRATIVE PERSONNEL — (a) Controller; leading Florida coast resort hospital $8000 up; also New York City, $9-$10,000. (b) Purchasing Agent; reorganize department leading university medical center hospital, midwest; $10,000. (c) Food service director; brand new hospital, Illinois; $7-$8000 start. (d) Laundry manager; 350-bed hospital near Chicago; $6000 start.

ANESTHETISTS—(a) Male; join M.D. in private practice near Seattle; fee basis. (b) Anesthetist; no O.B.; to cover service with another, 90 bed hospital near Dallas; business arrangements to be discussed. (c) M.D. needs second anesthetist for growing practice, 135-bed hospital; modern department, $8500; south. (d) Responsible for entire service small midwestern hospital, start $8500. (e) Staff; 350-bed hospital; either straight O.B. or surgery; Florida ocean city; $6000.

DIETITIANS—(a) Chief Dietitian; organize department, employ staff for new hospital near Chicago, $7-$8000. (b) Chief; 150-bed hospital all new equipment; modern plant near Cape Cod; top salary, maintenance.

DIRECTORS OF NURSING—(a) Director School and Service, 300-bed hospital near New York City; $10,000. (b) Director; experience nursing service; leading university hospital; person with progressive ideas, initiative required; some research; $10,000, east. (c) Director of Education; 450-bed hospital, N.L.N., school; 200 students, to $8000 start, midwest. (d) Direct newly created collegiate nursing program; starting enrollment 50 students; good salary; excellent fringe benefits; northwest. (e) In-service director; 300-bed hospital, Florida ocean city; $5500 up.

EXECUTIVE HOUSEKEEPERS—(a) Manage department fairly new 250-bed hospital near New York City; start $5300; maintenance available. (b) Male preferred for 320-bed hospital near Washington, D.C.; $6-$7500.

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POSITIONS OPEN

Medical Bureau—Continued

MEDICAL RECORD LIBRARIANS—(a) Director; 24 in department of 700-bed hospital with medical school affiliation, $6-$7500; Texas. (b) Chief; 300-bed hospital; ocean resort city, Florida; to $6000. (c) Chief; 300-bed hospital near Detroit; $6000 up.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—500-bed hospital; Michigan.

ADMINISTRATOR—(a) 125-bed hospital; Ohio; building program. (b) 50-bed hospital; Pennsylvania. (c) R.N. Administrator; 110-bed hospital; suburban New York.

OFFICE MANAGER—(a) 300-bed hospital; Missouri. (b) Comptroller; 115-bed Pennsylvania hospital. (c) Auditor; large mid-western hospital.

ANESTHETISTS—(a) $6500. (b) Chief pharmacists; $7200 up. (c) Research laboratory technicians; $5000. (d) Medical record librarians; $6000. (e) Administrative dietitian; 400-bed Ohio hospital. (f) Physical therapist; out-patient clinic-teaching center; $6000; large university city.

DIRECTOR, SCHOOL OF NURSING—(a) $9000; 400-bed eastern hospital. (b) Director, nursing service; 250-bed mid-western hospital; expansion program; University affiliation.

EXECUTIVE HOUSEKEEPER—(a) 175-bed hospitals, northwest; west coast. (b) 300-bed hospital; south. (c) 200-bed hospital; eastern New York. (d) 175-bed Ohio hospital.

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(Continued on page 200)

classified advertising

SCHOOLS-SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, BARNES HOSPITAL, 600 S. Kingshighway, St. Louis 10, Missouri.

BARNES HOSPITAL offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

The **PROVIDENCE LYING-IN HOSPITAL** offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

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POSITIONS OPEN

DIETITIANS—Positions open in two of the larger hospitals within a network of ten general hospitals operating in the Appalachian coal mining region of Kentucky, Virginia, and West Virginia; ADA membership required, with experience in administration, teaching, and/or therapeutics; 40 hour week, 4 weeks paid vacation, 7 paid holidays; Employee Health Program; Social Security, plus non-contributory retirement plan; salary open. Write or call collect: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia. Phone: BELmont 5-2424, Ext. 24.

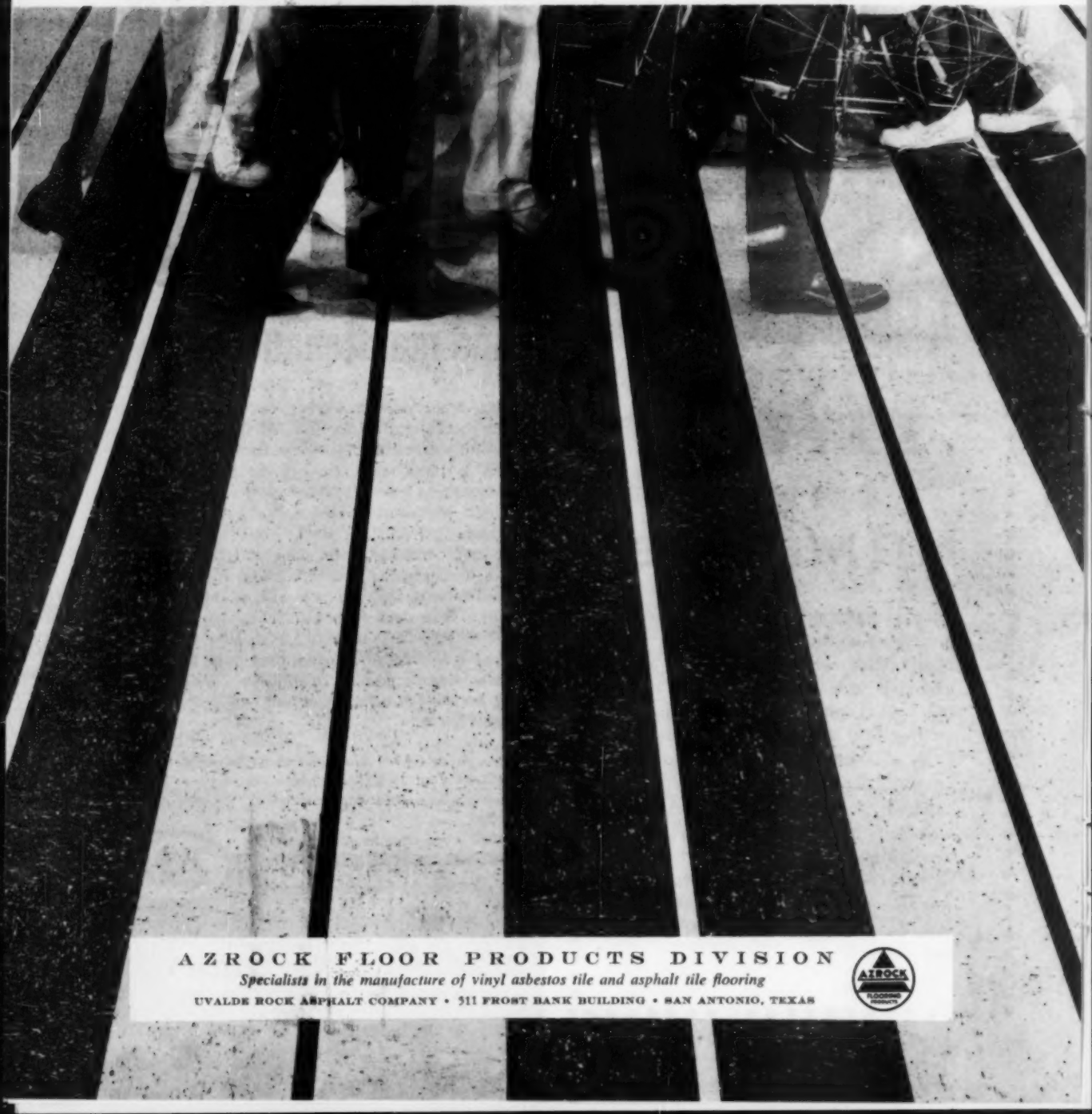
For additional information, use postcard facing back cover.

unique floor beauty that won't "walk off"...

Vina-Lux® 800 Series

Now, for hospital and institutional use, a vinyl asbestos floor tile with distinctive color chip styling that won't wear away under heavy concentrated traffic. The chip pattern is distributed at every level through the full thickness of the tile – yet Vina-Lux 800 Series costs no more than ordinary vinyl asbestos tile.

Vina-Lux 800 Series is made for installation over concrete – above, on or below grade – or over wood subfloors. In 12 coordinated colors: 9" x 9"; 1/8", 3/32" and 1/16" gauges. Consult your architect or write for free samples, color catalog and maintenance cost comparison with other types of resilient flooring.



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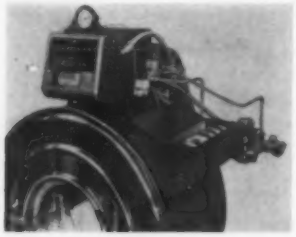
WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 225. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Jetro Washing Control Injects Supplies

The new Jetro washing control automatically performs all operations of the washing formula. It is mounted on the washer and reduces the operator's duties to merely filling stainless steel supply cups which automatically empty into the washer



at pre-determined intervals, followed by a jet spray that flushes the cup completely. The washing cycle is governed at all times by a formula chart which can be interchanged for different formulas. The Jetro Control is available with optional thermostatic regulation of incoming hot water temperature, and with a steaming device to raise temperatures. **American Laundry Machinery Industries, Cincinnati 12, Ohio.**

For more details circle #351 on mailing card.

Tele-Mike Pillow Speaker Has All Controls

Two-Way voice communication with the nurse, and radio and television reception are all included in a patient control center called the "Tele-Mike" Pillow Speaker, which is plugged by cable into the headplate assembly of the system. It replaces wall or ceiling speakers, permitting the patient to have privacy in communicating with the nursing station, and provides a

quiet speaker for TV and radio reception, eliminating the loudspeaker. The patient places or cancels calls to the nursing station by merely depressing the button marked "Nurse." Up to eleven TV and radio stations may be selected remotely by touching the press bar on the "Tele-Mike," and the Televiewer can be turned on or off and the volume adjusted through the same unit. **Motorola/Dahlberg, Golden Valley, Minneapolis 27, Minn.**

For more details circle #352 on mailing card.

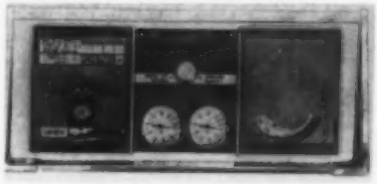
Surface-Mounted Luminaires Have Perforated-Steel Frames

Perforated-steel door frames on the new surface-mounted Westinghouse luminaires hold either glass lenses or aluminum louvers. Providing an attractive light pattern around the edge of the luminaire, the new models of type-SF luminaires accommodate two, three or four lamps having lengths of four or eight feet and ratings of 40 or 75 watts per lamp. Especially suited to low-ceiling applications where they provide direct lighting, the fixtures can be mounted either as individual units or adjacent to each other for continuous lines of light. **Westinghouse Electric Corp., P.O. Box 2099, Pittsburgh 30, Pa.**

For more details circle #353 on mailing card.

Steam Sterilizer Control System Increases Speed of Handling

An automatic high-vacuum pump to evacuate air rapidly from the sterilizing chamber and load, thus radically reducing load heat-up and over-all cycle time, is employed in the new Steam Sterilizer Control System introduced into the United



States by Castle. Components of the system are produced by Drayton Regulator and Instrument Company of England with whom Castle completed manufacturing agreements. The system is capable of quadrupling speed of conventional dry goods sterilization while increasing reliability of results, according to the report. It is available as an optional console for use with new sterilizing equipment or for conversion of existing units. **Wilmot Castle, 1944 E. Henrietta, Rochester 18, N.Y.**

For more details circle #354 on mailing card.

All-Purpose Clear Finish Introduced by Pratt and Lambert

Versatile, wear resistant and tough, Varmor is a new all-purpose clear finish which provides a satisfactory combination for outdoor and indoor application. It is a durable, tough finish for floors, walls, furniture and other surfaces. It withstands detergents, acids, alkalis, alcohol, salt water and cleaning fluids and requires no waxing. Ready to use, Varmor may be applied by brush, roller or spray on either new work or over old finishes in good condition. **Pratt & Lambert-Inc., Tonawanda St., Buffalo, N.Y.**

For more details circle #355 on mailing card.

Lectrapoise Operating Table for Instant-Response Positioning

The model 1080L Lectrapoise operating table features instant-response positioning through the full posturing range by a touch of the simple, positive dual safety controls located at the head end. Easily read dials indicate the exact degree of side tilt and Trendelenburg or reverse. The full length

top is x-ray permeable to permit radiography during surgery and a new "quick-grip" conductive rubber mattress pad clings to the four-section top through all positions with no tabs or snaps. The redesigned double-clamp legholder sockets provide instant, positive vertical and horizontal locking and the table has emergency mechanical bypass positioning in the event of power failure. **American Sterilizer Co., Erie, Pa.**

For more details circle #356 on mailing card.

Surgicel Absorbable Hemostat for Control of Hemorrhage

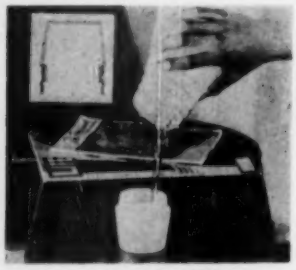
A unique new material for control of obstinate hemorrhage is introduced by Johnson & Johnson in Surgicel Absorbable Hemostat. Chemically, Surgicel is oxidized regenerated cellulose, manufactured by a new process that provides chemical and biological uniformity to ensure predictable hemostatic response. It does not depend on

the normal clotting mechanism or require the addition of thrombin to effect hemostatis, and it is completely absorbed by body tissues following application. It has been used in delicate neurologic surgery without untoward reactions, the manufacturer reports. Surgicel is available in knitted fabric type and a carded fiber form. **Johnson & Johnson, Hospital Div., New Brunswick, N.J.**

For more details circle #357 on mailing card.

(Continued on page 204)

Tomac Plastic Patient Carafe Is Autoclavable



Low cost and autoclavability to prevent cross infection are two advantages of the new Tomac Autoclavable Plastic Carafe for bedside use. Produced after eighteen months of research at American Hospital Supply, the durable polypropylene container is resistant to extremely high and low temperatures, making it especially adaptable to rotating drinking water systems. The tight-fitting cover, the lip of which fits inside the carafe to keep it clean, serves as a cup. **American Hospital Supply Corp., 1740 Ridge Ave., Evanston, Ill.**

For more details circle #358 on mailing card.

"Welcome Arrival" Packages for Income or Good Will

A gift which may be used by the hospital as a good will gesture, or sold in the gift shop is offered in the novel "Welcome Arrival" packages which should prove of considerable interest to parents of new babies. Designed to give the older child a position of importance, the "Welcome Arrival" package contains pure candy, fruit-flavored suckers, each in a heat sealed cellophane jacket announcing "I have a new baby brother" or "I have a new baby sister." The colorful box is designed to fold into an easily handled carrying tray to permit young brothers and sisters to pass out the "announcements" to their friends. Each box contains 35 suckers and sells at a relatively low price. **Gifts Exceptionale, 2613 Stevens Ave., Minneapolis 8, Minn.**

For more details circle #359 on mailing card.

Lifetime Silicone Nipple for Evenflo Nursers

Said to last ten times longer than pure gum nipples, the Evenflo Lifetime Silicone Nipple does not swell up or change shape

due to formula ingredients. It remains firm and strong for use with older infants and resists damage from biting. The design of the nipple prevents clogging and the Patented Twin Air Valve-Sure Seal eliminates excess air swallowing. It also locks the nipple in place to prevent leakage and pulling away from the bottle. **Pyramid Rubber Co., Ravenna, Ohio.**

For more details circle #360 on mailing card.

Enema Administration Unit Has Disposable Container

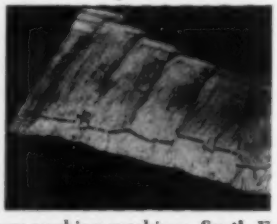
A disposable 1½ quart translucent container, complete with connector and rectal tube, plus clamp and lubricant, make up the new Pharmaseal Enema Administration Unit. Danger of contamination and cross infection are removed by the unit which is priced to enable hospitals to eliminate cleaning procedures by disposing of the

complete unit. It is designed for stacking to save storage space, and is easy to assemble, dispose of and use. **Pharmaseal Laboratories, 1015 Grandview Ave., Glendale, Calif.**

For more details circle #361 on mailing card.

Web-Foot Mop Line Now Offered in Six Weights

The patented Web-Foot line of mops is expanded to include eight, 12, 16, 20, 24 and 32-ounce weights to handle almost any mopping need. Other new features included in the line are a heavy duty, herring bond weave, selvage edge, cotton control band nylon-stitched to the mop tip, and an optional four or six-inch header. The Web-Foot patented mop design features a control band stitched to the lower portion of the mop to hold the yarn firmly in a perfect mopping pattern without tangling, raveling or wrapping around the mop handle or around furniture. The special yarn absorbs a maximum amount of water and, with the Web-Foot control, mops can be washed in



ordinary washing machines. **South Eastern Cordage, 815 Superior Ave., Cleveland 14, Ohio.**

For more details circle #362 on mailing card.

Adjustable Back Easy Chair Has Pull-Out Ottoman

An attractively styled geriatrics chair introduced by Hard features an adjustable back and an attached pull-out ottoman which disappears under the chair when not in use. Three positions are possible, upright, reclining and prone, and the short seat cushion makes it easier for older patients, or those weakened by illness, to get in and out of the chair. Model 7635 in the Mark 20 series of quality institutional furniture is carefully engineered. Heavy-duty construction is combined with lightness of appearance and the walnut or

maple solid wood arms blend with the decorator colors available in the upholstery. **The Hard Mfg. Co., Box 427, Buffalo 3, N.Y.**

For more details circle #363 on mailing card.

Surfaseptic Polyethylene Kills Bacteria

A new formulation, climaxing a ten-year search, is introduced by Dow Chemical as Surfaseptic. It is a bacteria-fighting polyethylene especially effective against staph organisms. Applications include toys, waste baskets, plastic door knobs, portions of telephone head sets, arm rests and other uses where health protection is important. Tests of baby toys made with the new material show that Surfaseptic polyethylene combats strains of harmful bacteria for the normal life of the toy. The bacteriostatic property of the formulations gives products the advantage of preventing bacteria growth, or the development of large colonies of bacteria. The bactericidal property aids in preventing the spread of infection. **The Dow Chemical Co., Midland, Mich.**

For more details circle #364 on mailing card.

Danco Sterile Telephone Has Built-In Sanitizing

A built-in santizing system which kills bacteria, molds and virus within seconds after the mouthpiece is returned to its rest position makes the new Danco Sterile Telephone especially important to hospitals. It employs the Westinghouse "Sterilamp" tube developed to destroy bacteria and other micro-organisms deposited in the air or on exposed surfaces and the tube is activated when the mouthpiece is replaced, releasing a controlled amount of

ultra-violet rays to destroy organisms and odors which may have been deposited by the user. The Danco Sterile Telephone is available in several colors. **Sterile Telephone Corp., 17 W. 44th St., New York 36.**

For more details circle #365 on mailing card.

(Continued on page 206)

Typical patients' room at Faith Hospital, St. Louis, Missouri. Architects: Joseph D. Murphy and Angelo G. Corrubia, St. Louis.

The Open World is a nurse's aid at Faith Hospital

Daylight and sunshine brighten the rooms. From their beds, patients see a wide, open world of blue sky, clouds and trees. For each room in this hospital has wall-to-wall windows.

And since these windows are glazed with *Thermopane*® insulating glass, patients get nature's therapy with none of her discomforts. Rooms stay cooler, despite summer heat; rooms stay warmer, despite winter wind; rooms stay peaceful and quieter, despite the thousands of cars roaring by.

"*Thermopane* windows are a big help," says the Chief Engineer. "In winter, they let in solar heat . . . thermostats in rooms on the south side shut off one-third faster than in other rooms. And the lack of condensation gives us better humidity control. This hospital is air conditioned with hot water in winter and cold water in summer—individually controlled, room by room. But our studies *prove* that *Thermopane* has helped us save considerably on utilities, as compared with hospitals of equal size."

For technical information on *Thermopane* and other L·O·F glass, consult your architect. Or ask your L·O·F Glass Distributor or Dealer (listed under "Glass" in the Yellow Pages). Libbey·Owens·Ford Glass Company, Toledo 1, Ohio.

L·O·F GLASS
THE QUALITY MARK TO LOOK FOR

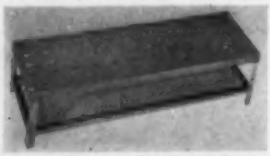
Thermopane®
INSULATING GLASS

Made in the U.S.A. only by

LIBBEY·OWENS·FORD

Tooth Brush Holder
Practical For Large Institutions

Designed for use in mental hospitals, nursing homes and similar institutions as a practical means of storing patients' tooth brushes, the Pratt Tooth Brush



Holder is made entirely of stainless steel to permit sterilization. It is 8½-inches wide and available in lengths depending on the number of patients in the room or ward. It is 6½-inches high to hold brushes upright for drainage. **Pratt Hospital Equipment Mfg. Co., 3007 Southwest Dr., Los Angeles 43, Calif.**

For more details circle #366 on mailing card.

Covered Hamper
for Contaminated Linen

With all exposed weld joints smoothly polished, the Debs No. F-92 Covered Hamper for contaminated linen has a lower shelf to keep the bag off the floor. A foot-pedal opens the hinged protective cover for easy removal of the bag when full. Four-inch conductive rubber swivel casters make the hamper easy to push to place of need, and it accommodates 18-inch diameter laundry bags, either draw string or self-closing. **Debs Hospital Supplies, Inc., 3990 Northwest Highway, Chicago 31.**

For more details circle #367 on mailing card.

Poster-Printer Produces
In One or More Colors

A machine that will print on any type of board up to 12½ by 10 inches in size, the new Ten-Eight Craftool Poster-Printer economically and efficiently produces posters, displays, cards, block prints and other items in one or more colors. Simply set up, the 16 by 14 by 19-inch machine can use any standard printer's type or combinations of type, wood blocks, linoleum cuts, wood engravings or electros. **Craftools, Inc., 398 Broadway, New York 13.**

For more details circle #368 on mailing card.

Disposable Urinal Cover
Flushes Away

Made of the same stock as Busse flush away bedpan bags, the new flush away urinal cover is of white tissue paper, strong enough to serve as a cover but thin enough to flush away as easily as toilet tissue without clogging plumbing. An imprinted space is provided for recording patient's name, room number and other data. **Busse Hospital Products, 64 E. 8th St., New York 3.**

For more details circle #369 on mailing card.

Personal Call Paging System
With Pocket Receivers

The Multitone Personal Call is a new selective electronic staff locating and paging system with pocket receivers. It combines both voice and beep signals and consists of a compact transistorized transmitter, a simple wire loop antenna surrounding the area to be covered, and a small five-ounce pocket receiver. Installation and operating costs are at a minimum, and the transmitter, about the size of a standard typewriter, is easy to operate

with very little training. When the operator presses a key on the transmitter, the doctor or other individual receives a beep signal which is private and not received by others using the system. The wearer puts the receiver to his ear, presses a button, and receives a spoken message from the operator. The shockproof receiver operates for weeks on inexpensive re-chargeable batteries which are easily changed when necessary. No F.C.C. license is required for installation. **Multitone of Canada, Ltd., 24 Merton St., Toronto 7, Ont., Canada.**

For more details circle #370 on mailing card.

(Continued on page 208)

New—from Colgate-Palmolive Research—

COLEO

Anti-Bacterial Deodorant Soap with T.C.S.A.

Reduces Skin Bacteria!
Gives Deodorant Protection!

Used every day, reduces skin bacteria an average of 85% . . . chases offensive odors

Non-toxic . . . non-irritating—pleasant fragrance

Lathers freely in hard or soft, hot or cold water

Distinctive yellow color for ready identification

Available in 1, 1½ and 3-oz. sizes. Unwrapped for greater convenience.

Other Hospital Products for Dependability . . . and Economy!

New! **Colgate Institutional Odorless Florient Air Deodorant**

A spray deodorant that reduces bacteria and virus count in the air . . . kills offensive odors without perfuming while it helps sanitize the air. No wick, no wait, no waste, no fragrance that might upset patients. In 1-lb. aerosol cans.

New! **Colgate Spot Disinfectant Spray with Permachem**

Kills on contact most bacteria and fungi that can cause infection, odors, mold and decay. Hospital tested . . . safe on surfaces . . . non-staining. Disinfects soiled linen and hampers, spillage on floors, bed pans, bedding, etc. In 1-lb. spray containers.

New! **Colgate Super Ben Hur**

A synthetic detergent cleaning powder that *fights germs* as it cleans. Acts as a bacteriostat and fungistat on germ-laden surfaces. Gentle on the hands—fast, efficient and economical. In 100-lb. and 25-lb. drums.

Colgate Coleo Laboratory Glassware and Surgical Instrument Cleaner

Dissolves quickly, cleans thoroughly and rinses freely. Efficient blood-removal action makes it especially desirable for cleaning surgical instruments and laboratory equipment. In 50-lb. and 100-lb. fiber drums and 5-lb. cans, 6 to the case.

Write **FOR LITERATURE AND PRICES TODAY**

Associated Products Division

COLGATE-PALMOLIVE COMPANY

300 Park Avenue, New York 22, N.Y.

Atlanta 8, Ga. • Chicago 11, Ill. • Kansas City 11, Mo.
Newark 2, N.J. • Oakland 12, Calif.

Antiseptic Skin Cleaner in Soft Paper Towel

Impregnated and moistened with Zephiran chloride, perfume, chlorothymol and

alcohol, Zephiran Towelettes are handy, disposable antiseptic skin cleansers in the form of soft paper towels. No soap, water or towel is required. They are folded and packaged in individual foil containers for convenient handling and carrying, ready for use at bedside for bed patients and in pockets or purses for ambulant patients. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #371 on mailing card.

Strong Plastic Liners for Refuse Disposal

Strong, non-porous polyethylene film is now available in plastic bags tailored especially for hospital refuse disposal. The bags are watertight, easily closed, and can be collected on trash carts and incinerated without reopening. They are available in a number of sizes for use as can liners to reduce labor costs of refuse collection and disposal, and the cleaning of waste baskets and refuse cans. **The Kordite Co., Dept. H, Macedon, N. Y.**

For more details circle #372 on mailing card.

Heller "Magazine Minder" Rack Has Hard Lacquer Finish

Suited for use in hospital lobbies, lounges and other areas where a supply of

magazines must be kept available, the new "Magazine Minder" rack can display twenty-two or more magazines at a convenient height. The unit features a hard lacquer finished surface highly resistant to marking or scuffing, and is available in either oak or birch. **W. C. Heller & Co., Montpelier, Ohio.**

For more details circle #373 on mailing card.

Tray Card Holders in Stainless Steel

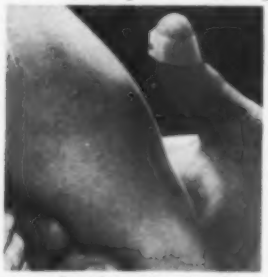
Tray card holders in stainless steel to match the Vollrath insulated pitchers, serv-

ers and other tray server items are now available. Known as No. 9208, they are easy to clean and give an added look of elegance to patient trays. **The Vollrath Co., Sheboygan, Wis.**

For more details circle #374 on mailing card.

Simple Device Facilitates Vaccination

No needle is required in small pox vaccination with the new Mono-Vacc recently introduced. The vaccine is administered with a plastic device that looks like a ring and has nine tiny points. A drop of vaccine is placed on the points,



the ring is placed on the thumb, and the user firmly presses it against the skin of the upper arm for speedy and practically painless vaccination. Children are quieter due to the ease and speed of the operation, scars are minimized and results are improved. **Lincoln Laboratories, Inc., Decatur, Ill.**

For more details circle #375 on mailing card.

V-Line Volume Refrigerators Have Floor Loading

Designed to receive standard utility racks, the new group of Victory V-line Floor Loader Refrigerators is designed to increase volume storage, feeding and serv-

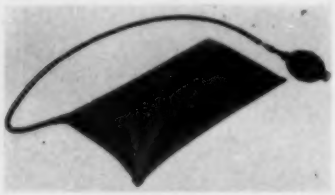
ice. The all stainless steel remote units will take almost any size utility rack and are available in one, two, three and four-section models, standard and pass-throughs. The racks roll easily into the refrigerator, positioned by special adjustable guide bars. **Victory Metal Mfg. Corp., Plymouth Meeting, Pa.**

For more details circle #376 on mailing card.

(Continued on page 210)

Rubber Elevator Cushion for Improved Surgical Position

Developed to provide better exposure in surgery and to relieve pressure on



axillary nerves and vessels while the patient is in lateral position, the Davol Conductive Rubber Elevator Cushion is inflatable. This permits it to be adjusted to the exact need and helps to reduce postoperative backache. **Davol Rubber Co., 69 Point St., Providence 2, R.I.**

For more details circle #377 on mailing card.

Concentrated Liquid Cleaner for Hard Surfaces

In addition to providing maximum cleaning action, Liquid Ben Hur meets the specifications of the Asphalt Tile Institute and Rubber Manufacturers Association. It cleans efficiently without producing excessive foam, thus eliminating baseboard spotting, cleans without stripping wax, picks up easily, and lifts stubborn soil without softening, bleeding or staining hard floor covering. Ben Hur can be used on terrazzo, marble, concrete, vinyl tile, linoleum, sealed wood floors, vinyl-asbestos tile, steel, painted wood or plastic upholstered furniture, rubber tile, leather, ceramic tile, venetian blinds, porcelain, and wall coverings. **Colgate-Palmolive Co., 300 Park Ave., New York 22.**

For more details circle #378 on mailing card.

Pic-A-Rack System Facilitates Dish Handling

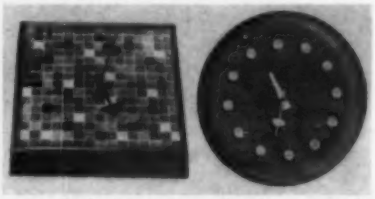
A two-part rack for use with dishwashing machines, which leaves half the

weight in the machine, is offered in the Seco Pic-A-Rack. A metal carrier takes the filled lightweight plastisol racks through the dishwashing machine. The racks full of clean dishes are then lifted out of the carrier, which remains for the next use. Color coded in red, blue and yellow plastisol for easy identification, Pic-A-Racks hold cups, glasses and silver, and also include an open utility rack. **Seco Co., Inc., 4560 Gustine Ave., St. Louis 16, Mo.**

For more details circle #379 on mailing card.

Decorator Clocks for Modern Buildings

Designed to complement modern architectural plans, the new Honeywell Deco-



rator clock faces are offered in a wide range of materials, including walnut, birch, teak, cherrywood, brass, chrome, leather and mosaic tile. The Decorator clock faces can be mixed or matched in a Clockmaster system installation to permit each clock to match the room or area, while functioning in the same manner as the other clocks in the system. **Minneapolis-Honeywell Regulator Co., 2820 Fourth Ave. S., Minneapolis 8, Minn.**

For more details circle #380 on mailing card.

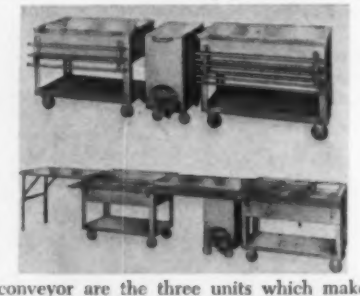
Amtico Floor Guards in Seven Types

Seven different types of vinyl casters and glides for floor protection are offered in the new line of Amtico Guards. Made of sturdy non-staining polyethylene plastic, Amtico Guards range in size from a small nail-on button glide for very light load applications to large square and round caster cups for heavy furniture. Swiveling glides and straight tip glides for one-inch chrome or aluminum tubular furniture are also included. **American Biltrite Rubber Co., Amtico Flooring Div., Perrine Ave., Trenton 2, N.J.**

For more details circle #381 on mailing card.

Aerohot MP Cafeteria System Made Up of Three Units

A food warmer with selective thermostatic controls, a cold pan unit with choice of four or nine-inch deep pans and a food



conveyor are the three units which make up the new Aerohot MP, a mobile cafeteria system designed to provide compactness and versatility. The food warmer and cold pan units have stainless steel covers which double as work surfaces when in place, and both have tray slide sections attached which fold down when not in use. The fully insulated food conveyor can hold seven deep pans with flat covers and is thermostatically controlled for keeping foods hot but can be used with a eutectic plate to keep foods cold. **Duke Mfg. Co., 2305 N. Broadway, St. Louis 6.**

For more details circle #382 on mailing card.

(Continued on page 212)

8 second magic in I.V. set-ups

remove metal seal and disc

plug set into center of stopper by a quick thrust

quickly invert bottle to automatically establish fluid level in drip chamber; clear tubing of air and infuse

CUTTER

THE FIRST MAJOR ADVANCE IN SOLUTION SYSTEMS SINCE DISPOSABLE SETS

THE CUTTER SAFTISYSTEM "28"®

the most advanced and progressive complete I. V. system ever offered to hospitals

can be set up in just eight seconds . . . provides a single point of entry for the set . . . eliminates the air tube . . . a single thrust plugs in the set . . . a single movement inverts the flask—simultaneously providing a visual check for vacuum and an automatic establishment of drip chamber level . . . allows only filtered air to contact solution . . . makes it easy to add medication at any time . . . saves time, especially on tandem hookups . . . decreases the danger of air embolism during blood infusion . . . compatible with all closed systems of I. V. administration.

CUTTER LABORATORIES • Berkeley, California

Stroup Patient Support Gives Nurse Extra Hands

Invented by a California nurse, the Stroup Patient Support enables a nurse to hold an immobile or even comatose bed patient comfortably on his side during bed adjustments or treatment. Described as the equivalent of an extra pair of hands for a busy nurse, the device consists of a broad, smooth disc affixed to an adjustable arm which clamps to the bed rail and projects over the patient so that the disc presses gently but firmly against the body. **Sierra Engineering Co., 123 E. Montecito Ave., Sierra Madre, Calif.**

For more details circle #383 on mailing card.

Self-Locking Caster Designed for Bed Frames

A new two-inch, white-wheeled caster is available from Bassick which permits free movement of unoccupied beds plus normal bedding, yet locks automatically when the bed is occupied. A spring-mounted axle allows the wheel to travel vertically under load until it engages the caster horn which prevents wheel rotation. The free movement of unoccupied beds facilitates cleaning, but the self-locking mechanism eliminates the manipulation of foot brakes. **The Bassick Co., 3045 Fairfield Ave., Bridgeport 5, Conn.**

For more details circle #384 on mailing card.

Trapezoid Water Cooler Has Space-Saving Design

The unique, space-saving trapezoid shape of the new General Electric wall and floor model water coolers permits drinking from either side as well as the

front. Mounted flush to the wall for additional space saving, the unit has completely enclosed components, hiding pipes or valves from view. Available with a carafe-filler accessory for cafeteria use. **General Electric Co., Commercial Equipment Dept. 14th & Arnold Sts., Chicago Heights, Ill.**

For more details circle #385 on mailing card.

Futron 25 Disinfectant Leaves No Odors or Stains

A highly concentrated disinfectant, detergent, deodorizer and descaler, Futron 25 is practical for use in nursing homes, hospitals and other institutions. The disinfectant kills both gram positive and gram negative bacteria and is non-toxic, non-flammable, non-corrosive and will not harm hands. The odorless concentrate leaves no stains and can be added to the final rinse in washing of linens or clothing for complete sterilization. **Hysan Products Co., 923 W. 38th Pl., Chicago 9.**

For more details circle #386 on mailing card.

Automatic Alternating Tourniquet Restricts Venous Return

Cordis Automatic Alternating Tourniquet restricts alternately and uniformly venous return from the limbs, alleviating acute pulmonary congestion. The device reduces nursing time for severe cardiac conditions as the constancy of reduced venous flow minimizes strain. **Cordis Corp., 241 N.E. 36th St., Miami 37, Fla.**

For more details circle #387 on mailing card.

(Continued on page 214)

WHAT'S YOUR C.I.Q.?*

TAKE THIS SIMPLE TEST TO FIND OUT

KNOWING THE CORRECT ANSWERS TO QUESTIONS ABOUT CANCER COULD SAVE YOUR LIFE

1 Leukemia is cancer of the blood-forming tissues.	TRUE	FALSE
2 All forms of life, including plants, can develop cancer.	TRUE	FALSE
3 Cancer is not contagious.	TRUE	FALSE
4 More men than women die of cancer.	TRUE	FALSE
5 Pain is a late cancer symptom.	TRUE	FALSE
6 Cancer can strike anyone at any age.	TRUE	FALSE
7 A biopsy (examination of suspected tissue removed from the body) is the only method of proving whether cancer is present.	TRUE	FALSE
8 Surgery or irradiation, or both, are the only means of curing cancer.	TRUE	FALSE
9 An annual health checkup is one of the most effective weapons against cancer.	TRUE	FALSE
10 Over one million Americans are alive today, cured of cancer.	TRUE	FALSE

SCORING: 10: Excellent
6 to 9: Fair
5 or less: Danger! For your own protection, learn more about cancer. Write to "Cancer" –c/o your local post office.

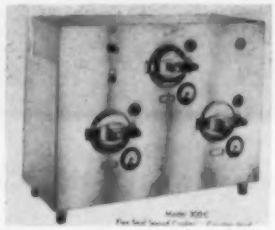
AMERICAN CANCER SOCIETY

ANSWERS: ALL TEN OF THESE STATEMENTS ABOUT CANCER ARE TRUE.

*CANCER INTELLIGENCE QUOTIENT

Flex-Seal Speed Cooker Now in Counter Model

The new Model 300-C Flex-Seal Speed Cooker is a counter model in the three-



compartment size. Developed for use where floor space is not available but large and varied production of fresh cooked vegetables is important, the Model 300-C will cook 750 servings per hour of fresh or frozen vegetables or fish without defrosting. **Vischer Products Co., 2815 W. Roscoe St., Chicago 18.**

For more details circle #388 on mailing card.

Single Shelf, Stackable File for X-Ray Film Storage

The Style No. 1611 single shelf, stackable economy model filing and storage units for x-ray film feature two improvements. The five guide slots expose three full-width compartments when either door is moved aside, and steel filler plates at each end of the cabinet prevent film from becoming lodged in the corners. **Bentson Mfg. Co., Aurora, Ill.**

For more details circle #389 on mailing card.

Housekeeping Cart Facilitates Maintenance

Mounted on four-inch ball bearing rubber-tired casters, the new Atlas Janitors and Maids Cart is easy to maneuver and

has protective rubber bumpers on corners. The cart has three shelves for linen storage, a platform for holding mop buckets and wringer, holders for mops and brooms, a large sized laundry bag which fastens at the handle, and a top tray for holding sanitary supplies. **Atlas Products Co., 3825 S. Racine Ave., Chicago 9.**

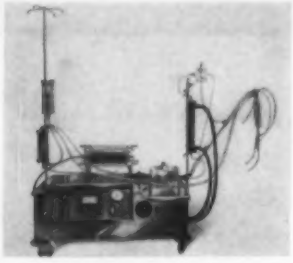
For more details circle #390 on mailing card.

Aluminum Foil Metal-Cals Identify Property

Manufactured to order in a wide variety of colors, in either matte or shiny finishes, Metal-Cals provide quick identification of property in the hospital. They are lightweight appliques which may be applied in seconds without tools or fasteners and resist wear and weather. When combined with a property listing, they are also helpful in adjusting claims in case of fire or other disasters. **C & H Supply Co., 415 E. Beach Ave., Inglewood, Calif.**

For more details circle #391 on mailing card.

Improved Heart-Lung Equipment for Heart Surgery

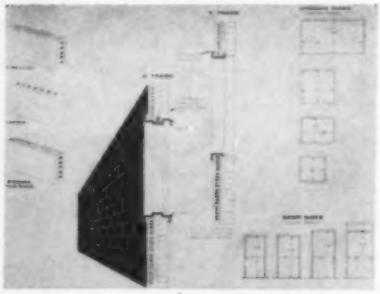


The Sigmamotor pump for open heart surgery is now offered in an improved model with two pumps, heat exchanger, oxygenator, water control valves, filter and bubble trap. It incorporates the Model TM-2 Pump into a stainless steel console with the necessary controls and accessories to make a versatile, efficient pumping unit for use with any type oxygenator. The console is designed for gravity venous return. Beside the pump speed controls and starting switch, the control panel includes tele-thermometer with probe, a water mixing valve and a water temperature indicator. Pumps are equipped with hand cranks for emergency operation. **Sigmamotor, Inc., 75 N. Main St., Middleport, N.Y.**

For more details circle #392 on mailing card.

Low Cost Wall Construction With Stark Thrift-Wall System

Three basic structural ceramic units and standard, pre-engineered, metal "surround" frames make up the low-cost Stark Thrift-Wall System of wall construction. Material and labor costs are reduced through elimination of expensive tile shapes and fittings. The system is adapt-



able to structural glazed tile with standard face dimensions of eight by 16, 5½ by 12, and 5 1/3 by eight inches. Any wall detailed in eight-inch increments can be constructed by using standard tile stretchers, corners and stretcher. **Stark Ceramics, Inc., Canton 1, Ohio.**

For more details circle #393 on mailing card.

Hot and Cold Disposable Cups of Foamed Plastic

Thermokup is the name given to a lightweight, sturdy cup, formed of Pela-

span expandable polystyrene beads made by Dow Chemical, and fully disposable. The foamed plastic acts as an insulator both to maintain temperature of either hot or cold beverages, and to protect the user from discomfort when the cup is used for hot drinks. There is no possibility of sogginess or of leakage since the one-piece molded construction eliminates seams, and there is no taste transfer. Available in six, eight and 12-ounce sizes, Thermokups may be used with tight-

fitting paper or transparent plastic lids if desired. They are distributed in the seven Western states by **Crown Plastic Cup Co., Fort Worth, Texas,** and in the rest of the country by **Mid-West-Pak Corp., Belvidere, Ill.**

For more details circle #394 on mailing card.

Gelso Glycerine Soap Is Non-Drying

A hypo-allergenic, delicate toilet soap in the form of a fluid gel is offered in Gelso Glycerine Soap. It is non-irritating, non-drying, non-roughening and soothing. It cleanses deeply while soothing the skin and has many uses. It is supplied in medical grade in half-pint squeeze bottles with Polytop cap, or in quart economy sizes. **Gelso Ltd., Box 3232, Chicago 54.**

For more details circle #395 on mailing card.

Liquid Scintillation Counting System for Low Energy Beta Emitters

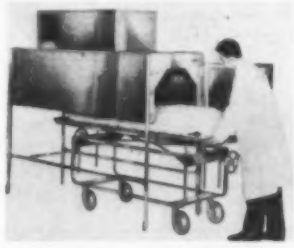
Developed specifically for use by research facilities which must perform precision analysis of large quantities of low energy beta emitters, the new LSC-20 Automatic Liquid Scintillation Counting System is a low-cost unit featuring automatic sample changing and data print out.

It consists of a compact top-opening deep freeze unit which contains the automatic sample changer and an instrument console containing the associated electronic circuitry and data printer. Simplicity of design and operation, and versatility of the sample cell are other features of the instrument. **Tracerlab, Inc., 1601 Trapelo Rd., Waltham 54, Mass.**

For more details circle #396 on mailing card.

Portable Cadaver Cooler for Temporary Storage

Developed to answer the need for a low-cost refrigeration system which could be easily relocated when necessary, the Lakeside Cadaver Cooling System is portable and requires a minimum amount of floor space. It reduces transfer and lifting



of bodies and permits the pathologist to perform autopsies at his convenience. When the table is lock-sealed to the refrigerated cabinet, then adjusted to maximum height, it lifts the entire cabinet off the floor for easy relocation of the complete unit. **Lakeside Mfg., Inc., 1972 S. Allis St., Milwaukee 2, Wis.**

For more details circle #397 on mailing card.

Kenwood Maternity Kit for Bedside Care

Developed to assist maternity patients in self-care, the Kenwood Maternity Kit contains all of the initial Kenwood dressing requirements in one complete package. Cost control is simplified and dressings are available at the bedside. There is less handling by personnel with greater convenience for patients. Each kit contains six Disposable Underpads, 24 O.B. Pads,

one box of Textile Cleaners and one Aren Snap-on Sanitary Belt. **Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.**

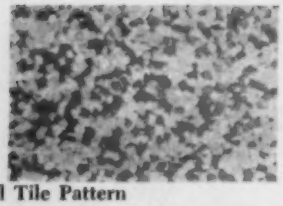
For more details circle #398 on mailing card.

Safetrode for Electrosurgery Eliminates Burn Source

The Safetrode is a large flat condenser molded in autoclavable neoprene which matches the capacity of the patient's body and induces energy into the patient for electrosurgery. No jellies or contour fitting are required and the device replaces metallic electrode plates. The Safetrode is placed on the operating table in a position approximating the trunk of the body and the patient can be moved at will to any position without fear of burns. **Birtcher Corp., 4371 Valley Blvd., Los Angeles 32, Calif.**

For more details circle #399 on mailing card.

(Continued on page 216)



Vinyl Tile Pattern in Terrazzo-Type Design

Verazzo, a new vinyl floor tile pattern which maintains the practical vinyl qualities of durability, stain resistance, marproofing and easy cleaning, also provides an attractive, colorful floor. Available in beige, pink, aqua, gray, green and blue. **Vinyl Plastics Inc., Sheboygan, Wis.**

For more details circle #400 on mailing card.

Dumbwaiter Car Has Movable Shelves

Designed especially for use in multi-story institutions, the new Matot dumbwaiter is electrically-powered and controlled from pushbutton panels at every floor stop. The dumbwaiter car can be provided with any arrangement of shelves which may be relocated or removed when desired, and door openings, available with vision panels, can be placed at work-level heights for hand loading or at floor level for roll-in of wheeled trucks and carts. The unit is useful for transporting food, food service or janitor supplies and bulky equipment. **D. A. Matot, Inc., 1533 W. Altgeld St., Chicago 14.**

For more details circle #401 on mailing card.

Thermopress Semi-Automatic Model for Fast, Efficient Mending

A compact, portable mending device for repairing linens of all kinds in the hospital is offered in the new HP-6 Thermopress Jr. The semi-automatic press, designed for fast, efficient mending, repairs most items in seven seconds and a variable timer provides the degree of control necessary to mend any type of fabric. Platens six by twelve inches increase production without sacrificing the heat and pressure required for a perfect mending result. The machine can be used in the laundry, sewing room or central

supply by simply plugging into a wall socket. **Thermopatch Corp., 2432 Grand Concourse, New York 58.**

For more details circle #402 on mailing card.

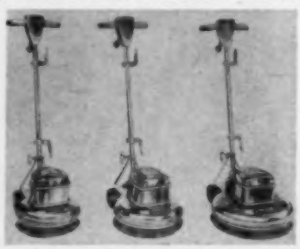
Drywall Partition Systems Added to U.S. Gypsum Line

Four new drywall partition systems are announced by United States Gypsum Company. Developed for use in institutions and other commercial buildings, each uses Sheetrock gypsum wallboard as a major component but differs in design and application. The new systems include Two-Inch Solid Partition, Double-Solid Partition, Metal Stud Partition and Ceiling and Wall Furring Systems. **United States Gypsum Co., 300 W. Adams.**

For more details circle #403 on mailing card.

Versatile Floor Machine in Three sizes

The Super DeLuxe 60 Medallion Series floor machines are available in 15, 17 and 20-inch sizes. The completely new machines feature a Step-Down Wheel Carriage Control which lowers the five-inch



wheels by simply stepping on a pedal at the rear. The machines roll on the wheels in up or down position, and the toe-operated trigger retracts wheels instantly without stooping. The Dual Safety Control Switch operates with either hand, and the specially designed capacitor-type G.E. motor, with extremely quiet operation and minimum height, is lubricated for life.

The Medallion machines are designed for dry-scrubbing, polishing, steel wooling, waxing, sanding and buffing, and are converted to efficient wet-scrubbers for all types of floors with a simple tank attachment. **United Floor Machine Co., Inc., 7715 South Chicago Ave., Chicago 19.**

For more details circle #404 on mailing card.

Fire Barrier Doors and Hardware Pass Underwriters Laboratories Tests

Rigorous tests conducted by Underwriters Laboratories were passed successfully by the new fire barrier employing double swinging doors by Overly with

newly developed fire exit hardware by Sargent. The fire barrier doors were awarded all available UL labels, A through E, by meeting all of the requirements of panic protection as well as fire protection. The doors were designed as an answer to the problem of fire protection considerations which require that interior and exterior barriers be securely fastened and capable of resisting the near explosive forces often generated by fires, thus limiting the spread of flame and smoke throughout a building, yet provide adequate egress facilities for panic-stricken occupants by opening quickly and unfailingly to even the light touch of a small child. By integrating bolts and mortise lock into the automatic activating mechanism of the twin panic bars, Overly and Sargent developed the fire barrier which solves both problems. **Overly Mfg. Co., Greensburg, Pa., and Sargent & Co., Water St., New Haven, Conn.**

For more details circle #405 on mailing card.

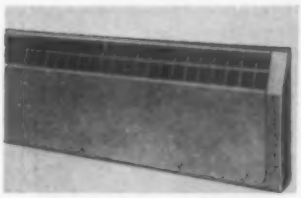
Auxiliary Laundry Machine for Large Institutions

The Unimac Twin 202 washer-rinse-extractor combination and Unidryer 37 are designed for use as auxiliary laundry equipment in large hospitals. Developed for fast, economical laundering of small items such as masks, caps, face cloths and the like, the 202 features a fast twelve-minute cycle and 1725 RPM rinse extraction for quick drying in the Unidryer 37. A variable temperature selector, magnetic door latch and self-cleaning lint screen are features of the 37. Capable of processing up to 120 pounds dry weight per hour in a total floor space of only 22 square feet, the equipment also protects small items from becoming lost in machines handling sheets and other large pieces. **Unimac Co., 802 Miami Circle, N.E., Atlanta 5, Ga.**

For more details circle #406 on mailing card.

Sunnywall Finpipe Radiation for Minimum Space Areas

Maximum heat output in minimum space is supplied with the new Crane Sunnywall type N finpipe radiation. Developed for institutional use, the neat



lines of Sunnywall enclosures lend themselves to modern interiors and units are available in a variety of enclosures and accessories for simplified installation. The complete line of fintube radiation provides clean convection heating with either forced hot water or steam radiation. **Crane Co., P.O. Box 780, Johnstown, Pa.**

For more details circle #407 on mailing card.

(Continued on page 218)

Non-Pyrogenic HemoVac Removes Hematoma

A small non-pyrogenic plastic tube with perforated section to be imbedded in the wound, a special needle for placing the wound tubing, Y connector and large tubing, and a suction evacuator make up the HemoVac for an improved method for constant removal of hematoma following operative procedure. The new treatment helps prevent infection while decreasing pain and speeding healing. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #408 on mailing card.

Onan Magneciter Generator Standard on 25KW Electric Plants

A new Magneciter Generator with Static Exciter and Voltage Regulator, formerly available only on larger units, is installed as standard equipment on all Onan 25KW gasoline driven electric plants. Constructed of rugged coils and windings, the Magneciter eliminates hundreds of electrical connections, requires no extra sensitive adjustments, is light weight and compact, and provides efficient performance in both primary and standby applications. **D. W. Onan & Sons Inc., 2515 University Ave. S.E., Minneapolis 14, Minn.**

For more details circle #409 on mailing card.

Dor-O-Matic Door Control Incorporates Hydraulic Cushioning

The Dor-O-Matic Hydra-Cushion concealed in the floor door control incorporates hydraulic cushioning for the control of doors at the end of the swing opening cycle. The new unit eliminates the damaging stresses transferred to vulnerable hinges and frames when doors are brought to a smashing halt when opened, and does

away with the need for door floor applied stop devices, as it incorporates a built-in back stop and optional hold open. **Dor-O-Matic Div., Republic Industries, Inc., 7346 W. Wilson Ave., Chicago 31.**

For more details circle #410 on mailing card.

Metrecal Liquid Diet Now in Ready-to-Drink Form

Metrecal is now available in ready-to-drink liquid form, packaged in 8-ounce cans. Each can provides a meal equivalent of 225 calories. Convenient 6-can cartons afford ease of handling and the individual cans permit dieters to vary the menu with chocolate, butterscotch, and vanilla flavors. **Mead Johnson & Co., Evansville 21, Indiana.**

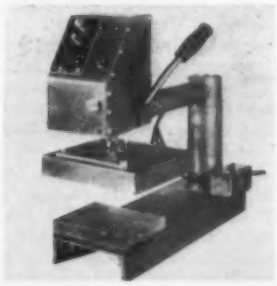
For more details circle #411 on mailing card.

Flexowriter Personalizes Letters at 100 Words Per Minute

Personalized letters can be written at 100 words per minute with the distinctive appearance of proportionally spaced type on the newly standardized Flexowriter President SFD. The automatic writing machine operates with coded paper tape which is punched and corrected, then read automatically to produce error-free copies. Codes can be included when the tape is punched to stop the Flexowriter during automatic typing for manual insertion of variable information. **Friden, Inc., One Leighton Ave., Rochester 2, N.Y.**

For more details circle #412 on mailing card.

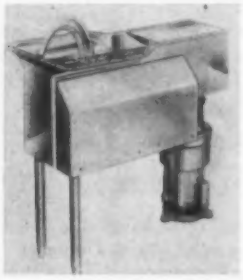
Portable Patchmaster for Garments and Linens



Repairing material in seconds with an absolute seal, the A-60 Royal Patchmaster is a portable machine for patching garments and linens. The Royal Seal patches, available in any color, are automatically sealed to the material through thermostatically controlled heat. A safety heat shield protects the operator and a patented swinging arm gives him a complete view of the work area. **Austin Supply Co., 210 S. Clinton St., Chicago 6.**

For more details circle #413 on mailing card.

High-Speed and Heavy-Load Operation With All-Purpose Scrap-Master



A large water-scrap-trough allows two or more operators to work at the same time, permitting both high-speed and heavy-load operation with the new, all-purpose Salvajor Scrap-Master water scrapping machine. Food waste is flushed away from soiled dishes and trays under a heavy plume of warm re-circulated water which carries it to the heavy-duty grinder for shredding. Even such waste as bones and cartons is easily disposed of in the grinder. **Salvajor Co., 7235 Central, Kansas City 14, Mo.**

For more details circle #414 on mailing card.

Flexible Wall Covering Also Protects Counter Tops

The Supreme series in Counter Corlon is a new flexible wall covering which serves also as a counter top or table surfacing material. Pastel vinyl accent chips give it an attractive appearance and the surface of clear vinyl makes maintenance easy. The flexibility of Counter Corlon permits installation without seams and it can be coved naturally into corners. Sold in sheets, in four color patterns, Counter Corlon is equipped with a special backing that is unharmed by alkaline moisture. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #415 on mailing card.

Double Seal Adhesive Tape Is Fully Porous

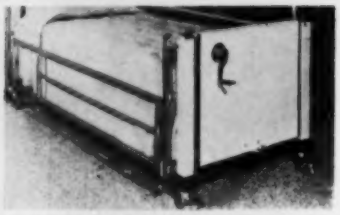
Scholl Double Seal Porous Adhesive Tape has minute openings throughout, so perfectly formed that they admit unobstructed passage of air through both the adhesive mass surface and the cloth backing. The strength of the backing cloth is maintained and the spread of the adhesive

mass ensures perfect adhesion. **The Scholl Mfg. Co., Inc., Surgical Supply Div., 213 W. Schiller St., Chicago 10.**

For more details circle #416 on mailing card.

(Continued on page 220)

Single Crank Operation for Uni-Drive Patient Bed



A single crank, which operates in conjunction with a three-way clutch, facilitates operation of the Uni-Drive bed. Rapid and almost effortless adjustment of head, foot and bed height saves time and makes it easier to make the patient comfortable. The crank is placed at a convenient height at the end of the bed to further facilitate its use. **Furniture Dynamics, Inc., P. O. Box 54114, Los Angeles 54, Calif.**

For more details circle #417 on mailing card.

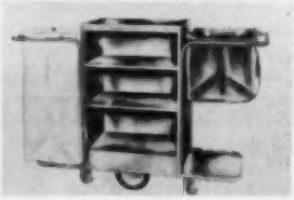
Dixie Disposable Pitchers Now in "Floral" Design

Now available in the "Floral" design, the Dixie disposable paper water pitcher developed especially for bedside use to help prevent cross infection, and equally useful for serving juices to patients, matches the complete matched food service in this design. The 32-ounce pitcher has a fitted lid with a die-cut tab to be opened for pouring, then closed to seal contents against air-borne bacteria. The "Floral" pattern is a soft green and brown design featuring delicate sprigs of flowers. **Dixie Cup Div., American Can Co., Easton, Pa.**

For more details circle #418 on mailing card.

Improved Linen Truck Is Entirely of Steel

The Linen-Master linen handling truck is a new model constructed entirely of



steel. It has three broad shelves 27 by 18 inches, large enough to carry 25 folded sheets and pillow cases, plus a matching quantity of towels and wash cloths. Two heavily-braced steel platforms will hold large pails, a vacuum cleaner, trash cans or sweepers, and a handy side rack holds up to five brooms and mops. Supplies, soaps and the like are carried in the large tray on the cabinet top. Two 10-inch ball bearing wheels and four ball bearing, rubber-tired swivel casters make the truck easy to handle and the size permits it to pass through narrow doorways. Canvas bags for handling soiled linen and trash are offered in a choice of six colors. **The Paul O. Young Co., Line Lexington, Pa.**

For more details circle #419 on mailing card.

Plastic Blood Filter for Open-Heart Surgery

Made of a halofluorocarbon plastic that is non-wettable, the new plastic arterial blood filter for open-heart surgery does not require siliconization and can be autoclaved repeatedly without extensive loss of transparency. The physical nature of the plastic has greatly reduced breakage during autoclaving and it can withstand continuous and rigorous use. The "Kel-F" powders produced by 3M can be molded with any standard equipment and the discs can be machined to close tolerances. **Sanford Plastics Div., Bonny Mfg. Corp., Maynard, Mass.**

For more details circle #420 on mailing card.

Nurse Call Plug Replacement Is Permanent Assembly

A hard polypropylene unit, complete with polyvinyl cord, is a permanent nurse call plug replacement designed to eliminate the necessity of replacing the entire call button assembly. The unit is indestructible, easy to clean, and does not deteriorate. One screw holds the cover on and terminal connections inside are designed for fast replacement of the cord if necessary. **Time and Sound Co., 2706 Main St., Riverside, Calif.**

For more details circle #421 on mailing card.

Quick-Acting Decalcifier Removes Solid Water Deposits

The solids deposited by water in hot water sterilizers, vaporizers and autoclaves are removed with Decalcifier, a quick-acting, economical product that has no dangerous acid fumes. The solution is not dangerous to equipment and can be used periodically to restore and maintain efficiency. **Lorvic Corp., 5553 Eastern Ave., St. Louis 12, Mo.**

For more details circle #422 on mailing card.

E-Z On E-Z Off Device Helps Handicapped

A self-help device created to assist the handicapped to help themselves is offered in the E-Z On E-Z Off. The simple lightweight aluminum device permits paralytics and others to put on and remove their own shoes and socks without assistance. **M and M Enterprises, P.O. Box 4654 University Station, Tucson, Ariz.**

For more details circle #423 on mailing card.

Positive Patient Identification With Sure-Band System

The Sure-Band system of positive patient identification includes bands of seamless surgical vinyl, insert cards, eyelets and a sealing punch. Greater strength and safety is provided with the stretchproof, Mylar reinforced bands, which have no sharp edges, joints, seams or welded parts,

and are available in colors in adult and pediatric sizes and in OB sets. Correlated numbers are carried on the mother-baby insert cards for additional safety, and all cards can be marked with pen, pencil, typewriter or addressograph. The five-ounce sealing punch, durable and autoclavable, is designed especially for the feminine hand with a short, light grip. **Twentier's Research, Inc., 708 E. Garfield, Phoenix, Ariz.**

For more details circle #424 on mailing card.

Wall-O-Matic Cleaning Machine Utilizes Compressed Air

A noiseless, non-electric wall cleaning machine called the Wall-O-Matic utilizes compressed air for continuous eight hour operation. The air powered machine thoroughly cleans walls and revitalizes painted surfaces with no dripping or streaking and may be used in busy rooms without disturbing normal routine and activity. Employing a special cleaning solution, the portable unit may be used on all types of walls and many types of acoustical ceilings, and a spray nozzle attachment cleans hard-to-get-at places and irregularly shaped objects. **Central States Maintenance Co., 125 Marion, Oak Park, Ill.**

For more details circle #425 on mailing card.

Plastic Utility Can Is Sanitary and Rustproof

Large utility cans, with or without casters, are now offered for institutional use

in the Utilican. Waterproof, sanitary, rugged and lightweight, the cans hold wet refuse or linen without fear of rusting, can be washed, disinfected, steam cleaned and sanitized, and the one-piece construction permits many uses for collection of waste, linen and the like, or for storage. The flexible walls absorb shock without denting and the cans are offered in forest green, black and white. **County Chemical Co., 1235 Newbridge Road, North Bellmore, L.I., N.Y.**

For more details circle #426 on mailing card.

Transistorized Dictaphone System Economical in Use and Service

Improved performance, easier servicing, increased clarity of reproduction and economy are built into the new Model RD6 Dictaphone Telecord Dictation System due to the use of transistors. Warm-up periods are eliminated and service time reduced by substitution of transistors for vacuum tubes. Offering all the advantages of the original Telecord System, the transistorized unit permits the dictator to pick up the handset and dictate histories, memorandums and the like from remote areas. It

can be adapted to internal phone systems and can utilize a number of recorders and desk phones. **Dictaphone Corp., 703 Third Ave., New York 17.**

For more details circle #427 on mailing card.

(Continued on page 222)

Pharmaceuticals

Dactil-OB

Indicated for the prevention of premature delivery, Dactil-OB provides nonhormonal therapy to prevent the onset of labor where there is a history of unsuccessful pregnancies or premature delivery. Each yellow, sugar-coated tablet contains 100 mg. ascorbic acid 50 mg. and hesperidin complex 50 mg. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #428 on mailing card.

Darvon Compound-65

A more potent dosage form of the nonaddicting, oral analgesic Darvon is introduced in Darvon Compound-65 containing 65 mgm. of the pain-relieving Darvon. It combines Darvon with the normal dose of acetylsalicylic acid, acetophenetidin and caffeine. It is indicated when increased analgesia is desired for acute, chronic or recurrent pain without an increase in the acetylsalicylic acid compound. **Eli Lilly & Co., 740 S. Alabama St., Indianapolis 6.**

For more details circle #429 on mailing card.

Enduron

Enduron is a new oral diuretic of the benzothiadiazine family, offering high potency, long duration of action and low toxicity. It has a duration of effect of at least 24 hours, and is indicated in the treatment and control of the edema associated with congestive heart failure, the nephrotic syndrome, hepatic cirrhosis, premenstrual tension and the administration of steroids, as well as a primary measure in the treatment of mild to moderate hypertension. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #430 on mailing card.

Ismelin

Ismelin is an antihypertensive agent indicated in moderate to severe hypertension. It acts at the nerve-arteriole junction where it apparently opposes the release and/or distribution of the pressor substance, norepinephrine, according to the report. **Ciba Pharmaceutical Products Inc., Summit, N.J.**

For more details circle #431 on mailing card.

Dianeal for Peritoneal Dialysis

Dianeal is a solution for performing peritoneal dialysis, which utilizes the living peritoneal membrane as a dialyzing membrane to remove toxic substances and metabolites from the body in cases of renal failure. It is supplied in two dosage forms that are identical in electrolyte composition but differ in their dextrose concentrations, one for treatment of patients with acute renal failure and the other for patients with massive edema. **Baxter Laboratories, Inc., Morton Grove, Ill.**

For more details circle #432 on mailing card.

Literature and Service

• A new high-sensitivity, high-speed, budget-priced recorder for general laboratory use, the Fisher Laboratory Recorder is described in the four-page illustrated **Bulletin FS-220,** available from Fisher Scientific Co., 717 Forbes St., Pittsburgh 19, Pa.

For more details circle #439 on mailing card.

• **Operating room cleaning procedures** are the subject of an illustrated brochure prepared by The Kent Co., Inc., Rome, N.Y. It describes a simple yet effective procedure for cleaning both between operations and at the end of the day. The Microstatic Technic is illustrated, including the use of a plastic sprinkling can to dispense detergent germicide on the floor area immediately surrounding the operating table following surgery. The solution then is picked up with a Microstatically equipped vacuum for quick between-operations cleaning.

For more details circle #440 on mailing card.

• The new **"LL Supplement,"** a four-page folder illustrating the many designs in lighting fixtures, lanterns and lamp standards available from Meierjohan-Wengler, 1100 W. Ninth St., Cincinnati 3, Ohio, displays a variety of contemporary and traditional models custom-fabricated in bronze, aluminum, stainless steel and wrought iron.

For more details circle #441 on mailing card.

• True-color panels for convenient selection are featured in a **folder on Musson "Safety Designed" Molded Rubber Stair Treads.** Available from The R. C. Musson Rubber Co., 1320 Archwood Ave., Akron 6, Ohio, the bulletin also illustrates new Perforated Entrance Mats, redesigned with smaller preforations.

For more details circle #442 on mailing card.

• **"Facts About Fever"** is the title of an educational booklet prepared and distributed by Becton, Dickinson & Co., Rutherford, N.J., for distribution to the general public.

For more details circle #443 on mailing card.

• The complete line of **Hobart Food Machines** is described and illustrated, with individual features of each, in a 56-page booklet available from The Hobart Mfg. Co., Troy, Ohio.

For more details circle #444 on mailing card.

• Information on the resources and services provided by their Atomic Energy Division is included in Bulletin 43B9541, available from Allis-Chalmers Mfg. Co., 1135 S. 70th St., Milwaukee 1, Wis. Entitled **"Atomic Energy at Allis-Chalmers,"** the 24-page illustrated booklet describes and portrays accomplishments in design and construction of reactors here and abroad.

For more details circle #445 on mailing card.

• A new **catalog of hospital restraints,** available from Humane Restraint Co., 824 E. Johnson St., Madison 1, Wis., includes information on a complete line of belts and straps, mitts and muffs, and heavy duty and light duty equipment for extreme cases or mild restraint. The eight-page illustrated booklet also describes operating table wristlets and anklets.

For more details circle #446 on mailing card.

• Two illustrated brochures that give complete information on **building with translucency** are available from Kalwall Corp., 43 Union St., Manchester, N.H. Translucent Panel and the Panel Unit Wall System are discussed in an eight-page booklet, and Skylights and Translucent Roofs in a four-page folder.

For more details circle #447 on mailing card.

(Continued on page 223)

• A visual treatise on the special problems of skin asepsis in the hospital, particularly as they relate to surgery, is available in a new film entitled **"Disinfection of Skin."** Authored by Dr. Carl W. Walter and produced by the Surgical Products Division of American Cyanamid Co., Danbury, Conn., the film has special animation effects defining the structure of the skin, the location of various surface and interior bacteria and how these may be affected by disinfecting methods.

For more details circle #448 on mailing card.

• Tables on the gas properties, cylinder contents and prices of both cylinders and gas mixtures, as well as data on regulating equipment are included in the new **Laboratory Gas Mixtures Catalog** available from Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.

For more details circle #449 on mailing card.

• A comprehensive 16-page catalog on the Dri-Heat Food System "for appetizing food service in every institution" is now available from Dri-Heat Food System, Inc., 500 N. Dearborn St., Chicago 10. **"The Dri-Heat" story** is told in text form, indicating how food is served fresh and hot at the patient's bedside with the Dri-Heat system. Full descriptive information on parts and operation of the system is included.

For more details circle #450 on mailing card.

• Facts of interest to all Americans, but particularly to administrators of institutions, on the problem of our water supply in the United States and what is necessary to assure a plentiful future supply are presented in a new color motion picture entitled **"Water Bill U.S.A."** Narrated by Walter Cronkite, the 27-minute film is available from Caterpillar Tractor Co., Peoria, Ill. for showing to executive and other groups.

For more details circle #451 on mailing card.

• Descriptions of the Sani-Mop Vac System and its operation, and illustrations of its components are included in **Bulletin ACV-800.** Available from U.S. Hoffman Machinery Corp., 103 Fourth Ave., New York 3, the four-page folder lists 12 reasons for installing the system.

For more details circle #452 on mailing card.

• **Catalog S-341** shows the six models of the Vapormatic moist heat food warmers and describes in detail the process by which temperatures are automatically maintained for individual foods. The six-page booklet, available from Bastian-Blessing Co., 4205 W. Peterson Ave., Chicago 46, includes charts and other information.

For more details circle #453 on mailing card.

• Corbin door controls, locks, hardware for specialized requirements, and the Corbin Keying Systems are covered in a new eight-page catalog now available from P. & F. Corbin Div., The American Hardware Corp., New Britain, Conn. Full descriptive information on this complete line of **Hospital Hardware** is presented with details on the custom-designed unit detention locks and other keying systems for use where controlled security with flexibility is important.

For more details circle #454 on mailing card.

(Continued on page 224)

• **"Burroughs Accounting Equipment and Techniques for Hospitals"** is the title of an eight-page folder, Form G 1212, available from Burroughs Corp., 6071 Second Ave., Detroit 32, Mich., that describes and illustrates the Series F line of accounting machines and indicates how they may be used in the preparation of patient records and statistical reports.

For more details circle #455 on mailing card.

• An informative illustrated folder on the **Dri-Hot Plate System** for transporting meals hot from food preparation area to the patient's bedside is offered by Legion Utensils Co., Inc., 21-07 40th Ave., Long Island City 1, N. Y. Line drawings show cross-sectional and top views of the system and illustrate the nesting feature.

For more details circle #456 on mailing card.

• A Catalog and Catalogette of the full line of **Schuco Medi Sprays** are available from Schueler & Co., 75 Cliff St., New York 7. Both publications feature the comprehensive line of Schuco aerosol medical sprays and are designed to provide ready references for purchasing.

For more details circle #457 on mailing card.

• Presenting comprehensive and up-to-date information on the application of high pressure decorative laminates, the **Panelyte Technical Data Brochure** is offered as an aid in design and specification work. Available from St. Regis Paper Co., Panelyte Div., 150 E. 42nd St., New York 17, the 24-page booklet gives authoritative information on a varied list of horizontal and vertical Panelyte applications.

For more details circle #458 on mailing card.

Suppliers' News

Becton, Dickinson & Co., Rutherford, N.J., manufacturer of hospital and laboratory equipment and supplies, announces formation of a new research and marketing organization to meet the needs of hospitals for improved laboratory services. Called **B-D Laboratories, Inc.,** the new company unites the production, financial control and research activities of three B-D subsidiary companies: **Baltimore Biological Laboratory, 220 Aisquith St., Baltimore 18, Md.; Cappel Laboratories, West Chester, Pa., and Falcon Plastics, 550 W. 83rd St., Los Angeles 43, Calif.**

Wilmot Castle Co., 1777 E. Henrietta Rd., Rochester 18, N.Y., manufacturer of surgical and sterilizing equipment, announces another addition to its manufacturing plant totaling 40,000 square feet.

Formica Corp., 4614 Spring Grove, Cincinnati 32, Ohio, manufacturer of Formica plastic laminate, announces the purchase of **Logue Woodworkers,** producers of Con-Dor-Lux doors, to simplify the specifying, ordering and ultimate installation of doors on large construction jobs.

Hicks & Otis Prints, Inc., 49 W. 33rd St., New York 1, will produce and market the **Curon Wall and Ceiling Covering** line, according to an announcement from **Reeves Brothers, Inc.,** who recently acquired the entire **Curon Div. of Curtiss-Wright.**

Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis., manufacturer and distributor of hospital supplies and equipment, announces the opening of an Ohio office and warehouse at **10468 Chester Rd., Cincinnati.** The branch will stock a complete line of hospital merchandise for faster and more efficient service to hospitals in the area.

The Spring Air Company, 666 Lake Shore Drive, Chicago 11, a 33-member national bedding licensee group with plants located in major marketing centers, and **Superior Sleeprite Corp., Chicago,** announce completion of a ten-year contract agreement under which the **Spring Air Company** will add complete lines of hospital and institutional furniture manufactured by Sleeprite to its quality bedding line. One of the important factors in the new operation will be a time sales financing plan developed by **Walter E. Heller & Co.** and enabling Spring Air to offer one and two-year financing to institutions.

E. R. Squibb & Sons, 745 Fifth Ave., New York 22, announces the opening of a new two million dollar packaging and formulation building at **New Brunswick, N.J.** More than 200,000 packages a day will be processed and packaged in the new unit, including antibiotics, hormones, tranquilizers and other medicinals.

Western Industries, Inc., 2742 W. 36th Place, Chicago 32, manufacturer of automatic parking gates, announces the signing of a distribution agreement with **Pigeon Hole Parking, Inc., Spokane, Wash.,** making the Chicago firm United States distributor for **Pigeon Hole Mechanical parking** installations.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

(continued on next page)

USE THIS CARD — (We pay the postage)

I am interested in the items circled— **February, 1961**

ADVERTISEMENTS

459	460	461	462	463	464	465	466	467	468	469	470
471	472	473	474	475	476	477	478	479	480	481	482
483	484	485	486	487	488	489	490	491	492	493	494
495	496	497	498	499	500	501	502	503	504	505	506
507	508	509	510	511	512	513	514	515	516	517	518
519	520	521	522	523	524	525	526	527	528	529	530
531	532	533	534	535	536	537	538	539	540	541	542
543	544	545	546	547	548	549	550	551	552	553	554
555	556	557	558	559	560	561	562	563	564	565	566
567	568	569	570	571	572	573	574	575	576	577	578
579	580	581	582	583	584	585	586	587	588	589	590
591	592	593	594	595	596	597	598	599	600	601	602
603	604	605	606	607	608	609	610	611	612	613	614
615	616	617	618	619	620	621	622	623	624		

WHAT'S NEW

351	352	353	354	355	356	357
358	359	360	361	362	363	364
365	366	367	368	369	370	371
372	373	374	375	376	377	378
379	380	381	382	383	384	385
386	387	388	389	390	391	392
393	394	395	396	397	398	399
400	401	402	403	404	405	406
407	408	409	410	411	412	413
414	415	416	417	418	419	420
421	422	423	424	425	426	427
428	429	430	431	432	439	440
441	442	443	444	445	446	447
448	449	450	451	452	453	454
455	456	457	458			

NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ ZONE _____ STATE _____

☐ **Enter my One Year Subscription To Modern Hospital ($5), Foreign ($7).**

INDEX TO ADVERTISEMENTS

(continued from preceding page)

(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File 37th Edition. (226)

why
you
can expect more
from

Ilosone

Lilly
QUALITY / RESEARCH / INTEGRITY

Ilosone®

(propionyl erythromycin ester lauryl sulfate, Lilly)

■ *"The high levels, plus prolonged duration of antibacterial activity and no decrease in absorption when given with food, should provide greater therapeutic effectiveness . . ."*[1]

1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:320, 1960.

Ilosone, in its more acid-stable form, eliminates the need for an "empty stomach" for effective antibiotic therapy. Food no longer interferes with absorption to any great extent. Moreover, enhanced absorption from the intestine in comparison with that of older forms of erythromycin assures greater certainty of therapeutic response. Thirdly, Ilosone is notably safe. In a review of over 20,000 case reports, there were no serious side-effects or toxic reactions.

Summing up: Ilosone works decisively in a wide variety of infections.

Usual Dosage:

For infants and for children under twenty-five pounds of body weight, 5 mg. per pound every six hours; for children weighing twenty-five to fifty pounds, 125 mg. every six hours.

For adults and for children over fifty pounds, 250 mg. every six hours.

In more severe or deep-seated infections, these dosages may be doubled.

Available in Pulvules®, suspension, and drops.

132519

Plate No. 1084

Lobby walls are of Romany·Spartan ceramic mosaics in a custom pattern.

How to be an expert on wall finishes

Operating room walls are of Romany·Spartan glazed tile, each individually designed and color styled.

Plate No. 1093

FRANK CUNEO MEMORIAL HOSPITAL, Chicago, Ill.
Architects: **BELLI & BELLI CO. INC.,** Chicago, Ill.
Tile Contractor: **McWAYNE COMPANY,** Chicago, Ill.

Select Romany·Spartan ceramic tile.

Exclusive "Quickset"-mounted Romany·Spartan installs faster—keeps initial cost low. Romany·Spartan never needs replacement—is impervious to damage from ordinary causes—lasts a building lifetime. And it's so easy to care for that you save maintenance dollars year after year after year. That's why walls and floors of time-tested Romany·Spartan ceramic tile guarantee lowest lifetime cost.

Beauty? You can choose from literally thousands of patterns, colors, sizes and finishes to create the precise effect most pleasing to you.

Your architect will be glad to provide detailed information and show samples. Consult him. United States Ceramic Tile Company, Department MH-19, Canton 2, Ohio.

ROMANY SPARTAN

UNITED STATES CERAMIC TILE COMPANY

CERAMIC TILE

MEMBER